ary of

April, 1955

Medical Economics



U.S. Okays Kintner Pension Plan

Also in this issue:

The G.P. 'Wants In'

Socialized Medicine Comes to Sweden

Ways to House Records More Efficiently

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Rx INFORMATION

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INDICATIONS: Menopause, prostatic carcinoma, postpartum breast engorgement.

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SAFETY: TACE produces a minimal incidence of withdrawal bleeding so commonly observed following estrogen therapy of the menopause. In both sexes, TACE is generally well tolerated, thus minimizing such side effects as nausea, vomiting and fluid retention.

DOSAGE: For relief of menopausal symptoms, 2 TACE Capsules, or 2 cc. TACE Oral Drops (in cold water), daily for thirty days, is generally a course of therapy. In severe cases when symptoms recur, additional short courses of TACE may be required. For postpartum breast engorgement, 4 TACE Capsules daily for seven days. For palliative control of prostatic carcinoma, 1 or 2 TACE Capsules daily.

SUPPLIED: In bottles of 70 and 350 capsules, in 30 cc. bottles with calibrated dropper. One bottle of capsules or 2 bottles of oral drops usually suffice for a course of therapy.

References: 1. Greenblatt, R. B., and Brown, N. H.: Am. J. Obst. & Gyn. 63:1161, June, 1952
2. Ausman, D. C.: Wisconsin M. J. 53:322, 1954.
3. Woodhull, R. B.: Obst. & Gyn. 3:201, 1954.
4. Ivory, H. S.: J. Med. Soc. N. J. (In press).

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Medical Economics

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Panorama

Tells laymen why doctors need grievance boards • A.M.A. upholds panel plan ads • City practitioners urged to use smaller cars • M.D.s launch own blood program • Doctors warned against baby traffic

Hoover Report Is In

Too many people are getting medical care at Uncle Sam's expense. What's more, there's still too much waste and inefficiency in the Government's operation of its health services.

These, in essence, are the conclusions reached by the Hoover Commission after its lengthy investigation of Government medical activities. The Commission's report, which has now gone to Congress, contains a total of twenty-nine specific proposals for the reorganization, curtailment, and general improvement of existing Federal medical services.

Among the chief measures recommended:

¶ Creation of a Federal Advisory Council of Health to coordinate all Government health activities.

¶ Stricter procedures regarding the care of non-service-connected cases in Veterans Administration hospitals.

¶ Abandonment of all V.A. building projects except those actually under way.

¶ Closer integration of armed forces medical services and installations.

¶ Elimination of Federal medical care for military dependents.

¶ Abolition of Federal hospitalization and medical benefits for merchant seamen.

¶ A system of voluntary, contributory health insurance for all civilian employes of the Government.

¶ The closing down of twelve of the sixteen existing Public Health Service hospitals.

For a more complete presentation of these proposals, see page 203 of this issue.

Hospital Fee-Grab Ends

The widespread misappropriation of workmen's compensation case fees in New York City hospitals appears to have come to an end. The former chief of the state's Moreland Act Commission, Charles S. Hamilton, announced shortly before his

retirement that, as far as his investigators had been able to determine, none of the offending hospitals had failed to comply with the state's strict order to clean house.

Among abuses the commission claims have now been wiped out:

¶The appropriation, by hospitals, of insurance fees earned by their staff physicians.

¶ The practice of submitting bills at specialist rates for services performed by residents, internes, and nonspecialists.

¶ The arbitrary distribution, by service chiefs, of fees earned by individual doctor-members of their staffs.

Writer Tells Why M.D.s Need Grievance Boards

After the doctor had removed the steel splinter from the little girl's eye (thus presumably saving her sight), he presented the father with



Eagle Builds Nest For M.D.

When Dr. William Rosenkranz [▲] came to Eagle, Wis., a new office [▼] was ready for him. It had been built by the townspeople who hadn't had a doctor for three years. They'd been so anxious to have one, that they'd put up most of the money themselves.



a bill for $1,200. The father expressed his gratitude but was staggered by the size of the fee.

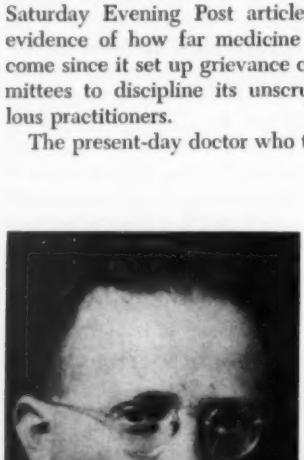
"What's the matter?" asked the M.D. "Don't you think your daughter's eye is worth $1,200?"

"My daughter's eye is worth a million dollars," said the father. "But we just haven't got $1,200 now."

"Get it," said the doctor.

This incident took place ten years ago in Alameda County, Calif. Milton Silverman cites it, in a recent Saturday Evening Post article, as evidence of how far medicine has come since it set up grievance committees to discipline its unscrupulous practitioners.

The present-day doctor who tries to gouge his patients is usually—and quickly—brought into line by his colleagues, Mr. Silverman tells his readers.



DR. BEN E. LANDESS
The panel plans win a victory

Panel Plan Ads Upheld

In a recent move, the A.M.A. Judicial Council completely cleared Dr. Ben E. Landess of New York.

Affiliated with the Health Insurance Plan of Greater New York (H.I.P.), Dr. Landess had been censured for unethical conduct by his county medical society when it discovered that H.I.P. was using his name in its advertising. The censure was upheld by the state society.

The Judicial Council reversed the earlier decisions. It ruled that Dr. Landess "had nothing to do with the preparation or distribution of the advertising," and hence was blameless. It held, further, that advertising by panel plans is perfectly legal—as long as the ads emanate from groups that are organized "in accordance with law" and as long as they don't overstep the bounds of propriety.

M.D.s Advised to Shun Financial Audits

What's the best way to wipe out fee splitting? The American College of Surgeons has felt for some time that the answer is to require every hospital-affiliated physician to submit his books for an annual financial audit.

But the Chicago Medical Society, for one, feels this may be an unwarranted invasion of the doctor's privacy. Accordingly, it has advised its members not to agree to such audits.

Does this stand constitute a declaration of war on the A.C.S.? Society officials decline to say. But it's no secret that they're out to prevent other hospitals from following the example set by Chicago's giant Michael Reese Hospital. That institution's staff members recently agreed unanimously to have their books audited.

Suggests Smaller Cars For Easier Parking

Let the big-city physician ease his parking problem by simply driving a small-size car, says New York Medicine. Such a car—foreign or domestic—will fit into spaces too cramped for ordinary cars; and it's likely to be cheaper to buy and to run, the journal reminds its readers.

"To push the thought to still another stage," it adds—quite seriously—physicians might "agree upon some uniform color for these small cars . . . so the police would know at a glance that when the car is parked the doctor is on a medical call. Perhaps the seal of the society could go on the doors. One would hope that this would decrease the number of tickets which physicians now receive . . ."

The publication even suggests

Snapshots

M.D.-OWNED PHARMACIES may be boycotted by Kentucky pharmacists. Their newly amended code says it's unethical for any pharmacist to "use his professional knowledge in a way that would increase the income of members of other health professions."

FOREIGN-TRAINED M.D.s face new hurdle: The National Board of Medical Examiners says that from now on, they'll be admitted to its certification examinations only at the request of a state board.

"CRASH" FUND: M.D.s in Preston City, Conn., scene of a recent air crash, pooled all fees received from the injured into a common fund for new hospital equipment.

DOCTORS' FEES too high? One out of three people in Minnesota thinks so, a Minneapolis Sunday Tribune poll shows. It adds that one Minnesotan in five feels M.D.s don't take enough personal interest in their patients.

KOREAN G.I. BILL has sent 4,926 veterans to medical school, and another 1,705 for premedical training in the first two years of its existence, says the V.A.

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that if Manhattan's 8,500 doctors are interested in buying small cars, "it might be possible, through the mass purchasing power of the society as a whole, to [get them at] extra-favorable prices."

Family Doctor Plumps For 'Hover' Charge

Should the G.P. "hover" over his hospitalized patient whose care is now in the hands of a specialist? According to Boston's Norfolk Medical News—which apparently first used the term "hover" to define the continuing attendance of the family doctor on an informal basis—he certainly should.

In fact, says the News, any G.P. who *doesn't* watch over his hospitalized patients both before and after surgery is remiss in his job. But it adds that, "with an exception or two," the physician shouldn't charge for such hovering.

Commenting on this point of view, Dr. Norman R. Booher of Indianapolis says he sees no need for such an admonition against charging. If the patient and his family tell the doctor they'd like him to "hover," there's no reason why he shouldn't charge for doing so, he maintains in a letter to the Journal of the Indiana State Medical Association.

"I have always sent personal bills for this service with a full explanation . . . and I have never failed to receive cheerful remuneration," says Dr. Booher, who heads the General Practice Section of the state society. Naturally, he adds, the specialist and the family doctor must render separate bills in such an event, "so that there can be no question about splitting fees."



DR. NORMAN R. BOOHER
His formula: "hover" and charge

Doctor-Sponsored Blood Plan Gets Under Way

Doctors in New York State have finally launched their own campaign to spur blood contributions. Their project: a "Blood Assurance Program," under which the gift of one pint of blood will entitle the donor *and* each member of his immediate family to receive up to four pints a year.

The plan will operate under the

auspices of the state's Blood Banks Association (which in turn is sponsored by the state medical society). But it won't "compete or interfere with the essential blood procurement work being done by the Red Cross or other nonprofit collection agencies"; it will merely attempt to supplement the blood provided by these agencies, says the program's executive chairman, Dr. Solomon Schussheim.

Nervous Gunman Invades Doctor's Office

The thin, pimply-faced young patient had acted strangely ever since he'd come into the doctor's reception room. While awaiting his turn, he had paced up and down like an expectant father, smoking endless cigarettes and scattering ashes on the floor. Then, he'd been extremely hesitant and vague about giving the receptionist the details of his medical history. And, finally, when the nurse asked him to remove his jacket and roll up his sleeve so she could get a blood sample, he put up a hot argument.

He wasn't taking off any clothes, he made it clear, until he'd had a chance to speak to the doctor about the fee.

Only when the youth was finally ushered into the consultation room did the reason for his strange behavior become apparent: He hadn't wanted to talk money but to take it.

[MORE ▶

Snapshots

CAR-BUYERS are being urged to shop around before making a choice. Seems competition is stiffening and there are more and more good "deals" to be had.

PANEL CLOSED: In Connecticut, the Group Health Council, Inc., an organization modeled closely on New York's H.I.P., has dissolved itself before even getting under way. The announced reason: lack of public interest and support.

WHAT'S IN A NAME? Kenneth Crook, a Wisconsin farmer who was charging ailing neighbors $1 an hour to sit in his "uranium tunnel" (a room filled with bags of low-grade uranium ore) has been ordered to close shop.

M.D.s RANK FIRST: Doctors have more prestige than anybody, say high school editors polled by New York University. Next: lawyers, teachers, bankers, journalists.

HEALTH CENTER RAIDED: In Philadelphia, stunned public health officials fired the caretaker of a city-run health center, when a police raid disclosed that he had nightly been using it as a bar and gambling den.

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Pulling out a gun and pointing it shakily at the startled physician, Dr. William C. Jacobson, he croaked: "This is a holdup, buddy. And I mean business."

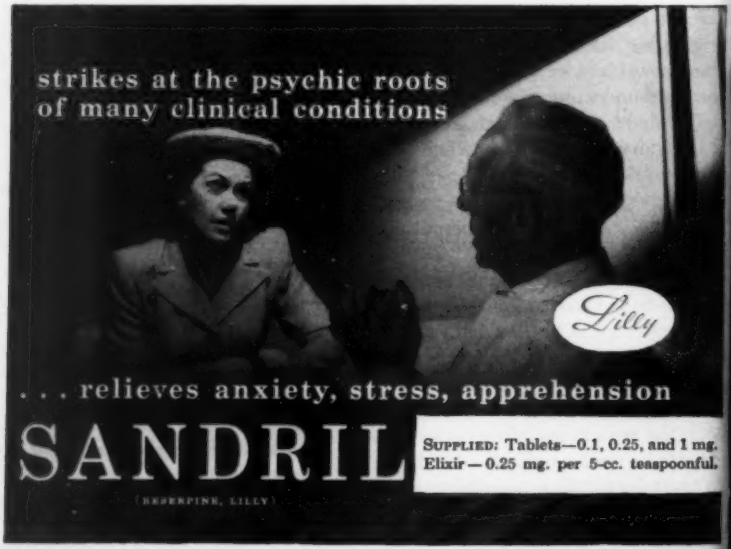
Yet his actions were anything but businesslike. Only after a considerable amount of nervous pacing and peering around did he eventually relieve the doctor and his X-ray technician of $250. And his job of trussing up his victims was most unprofessional:

Dr. Jacobson was able to wriggle free of his bonds and call the New York City police within minutes after the young bandit had decamped.

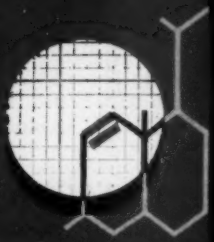
As of last month, the bumbling gunman still hadn't been caught. But the experience may have taught him that a life of crime is not for him. Says Dr. Jacobson: "That guy was a nervous wreck by the time he left my office. And the whole time he had us covered, he acted more like an ulcer patient than a professional thief. Why, at one point, he was so jittery that I even offered him a sedative."

Doctors Warned Not to Traffic in Babies

"This fall, I visited 40 doctors picked at random. When I said I was interested in [adopting] a baby, six of them told me to see a licensed



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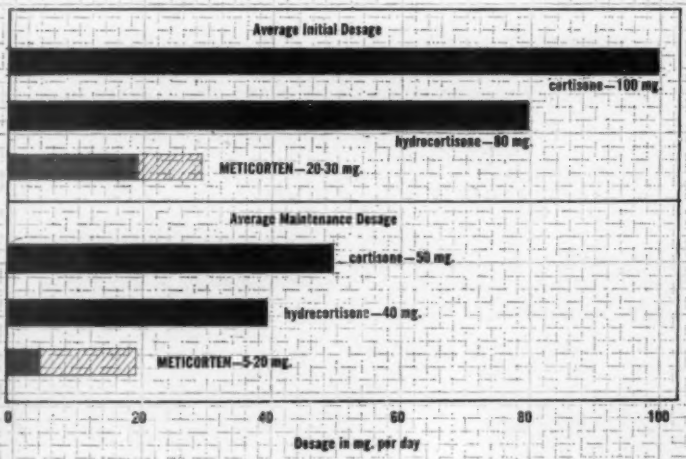
and

METICORTELONE

(metacortandralone, Schering)

Possessing three to five times the therapeutic effectiveness of cortisone or hydrocortisone, on a milligram for milligram basis, in rheumatoid arthritis, other so-called collagen diseases, and intractable asthma, METICORTEN and METICORTELONE are strikingly devoid of the major undesirable actions of sodium retention and excessive potassium depletion. Patients treated with these new steroids do not exhibit fluid retention. Sedimentation rate is lowered even where cortisone or hydrocortisone cease to be effective—"cortisone escape."

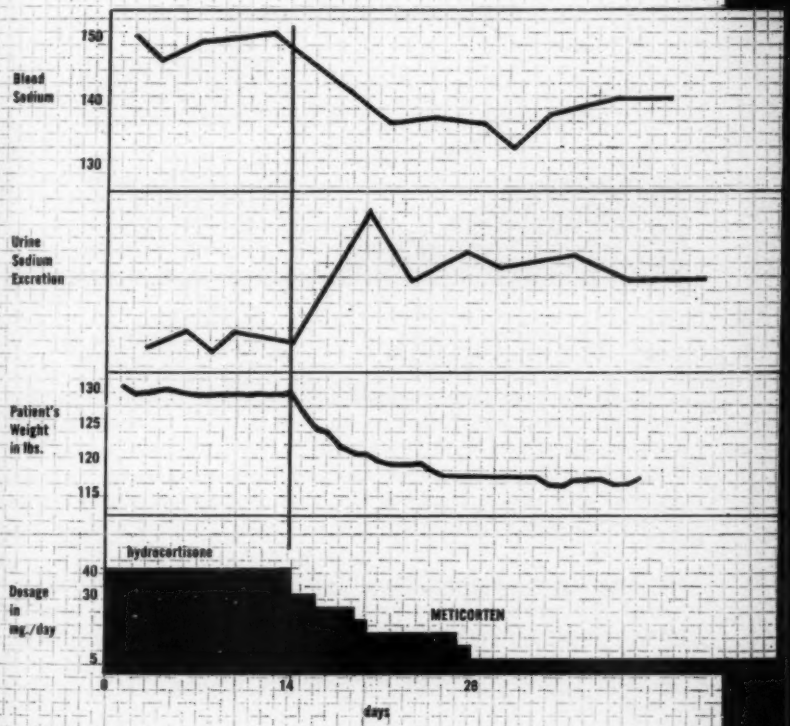
most effective in smallest dosage



graphic data typifying response to the new corticosteroids



avoids sodium and water retention



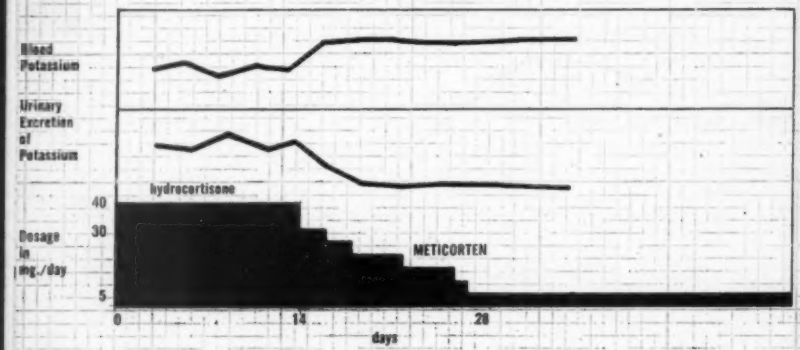
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FOR SAFER, MORE EFFECTIVE CORTICOSTEROIDS

no excessive potassium depletion



how to use METICORTEN

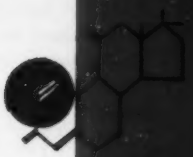
In the treatment of rheumatoid arthritis, dosage of METICORTEN begins with an average of 20-30 mg. a day. This is gradually reduced by 2½ to 5 mg. until maintenance dosage of 5-20 mg. daily is reached, usually by the 14th day. The total 24-hour dose should be divided into 4 parts and administered *after meals and at bedtime*. Patients may be transferred directly from hydrocortisone or cortisone to METICORTEN without difficulty. METICORTEN is available as 5 mg. tablets, scored, bottle of 30.

METICORTELONE* (metacortandralone, Schering) was also discovered by Schering research. It resembles METICORTEN clinically in the treatment of the so-called collagen diseases, and will be made available as soon as possible. The special properties of both compounds are being studied in other fields of therapy.

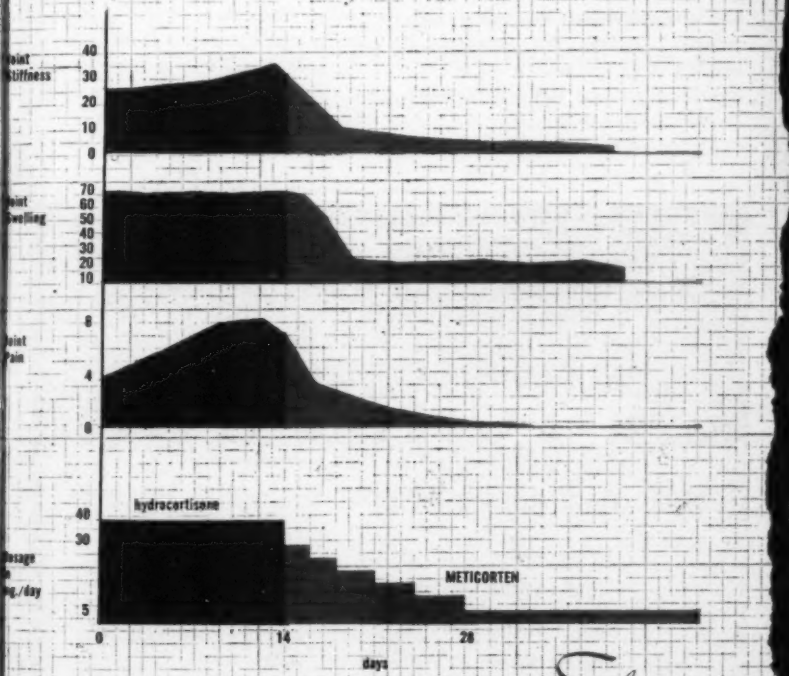
METICORTEN,* brand of metacortandracin. • METICORTELONE,* brand of metacortandralone.

*T. M.

excellent results obtained consistently, even in patients responding poorly to previous corticosteroids.



better relief of pain, swelling, stiffness



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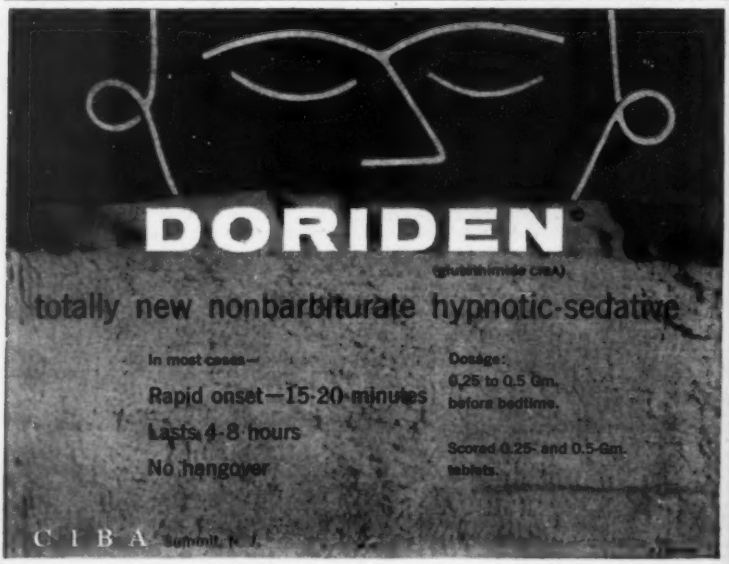
adoption agency. But the remaining 34, without any investigation of my background, said they would help. And not one, not even one, hinted that he wanted anything beyond his normal fees. They all wanted just to make people happy."

The man who made this count is Ernest A. Mitler, former special assistant to District Attorney Frank S. Hogan of Manhattan. He didn't really want to adopt a baby. He merely wanted to confirm what he had long suspected: that many well-meaning doctors are unwittingly helping to perpetuate what he describes as the country's flourishing "blind" market in babies.

Mitler contends—in a Look magazine article from which the above quotation is taken—that it's dishonest, no matter what the motive, to help *anyone* bypass the proper channels of adoption. What's more, he says, the doctor who does so may bring unforeseen trouble on the very people he's trying to help. One reason: As many as 40 per cent of the women "who let their children go through private placement" actually are married or have "other legal ties."

As an illustration of the unpleasantness that can result from a doctor's "well-meaning but uninformed act," Mitler cites the following case from his experience:

"Not long ago, a young man



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for true economy in urinary tract infections



1. Fast clinical and bacteriologic cures.
2. Helps shorten or eliminate hospitalization.
3. Helps get patients back to work sooner.

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In 30 minutes: antibacterial concentrations in the urine.
In 24 hours: a turbid urine is frequently clear.
In 3 to 5 days: complete clearing of pus cells from the urine.
In 7 days: sterilization of the urine in the majority of cases.

Furadantin exerts powerful antibacterial action against a wide range of gram-positive and gram-negative organisms, including bacteria notorious for their resistance.

With Furadantin there is no proctitis...no pruritus ani...no crystalluria ...no moniliasis...no staphylococcic enteritis.

Average adult dose: Four 100 mg. tablets daily, taken with meals and with food or milk before retiring.

50 and 100 mg. tablets. Furadantin Oral Suspension, 5 mg. per cc.

EATON LABORATORIES
NORWICH • NEW YORK

THE NITROFURANS—A UNIQUE CLASS OF ANTIMICROBIALS • PRODUCTS OF EATON RESEARCH

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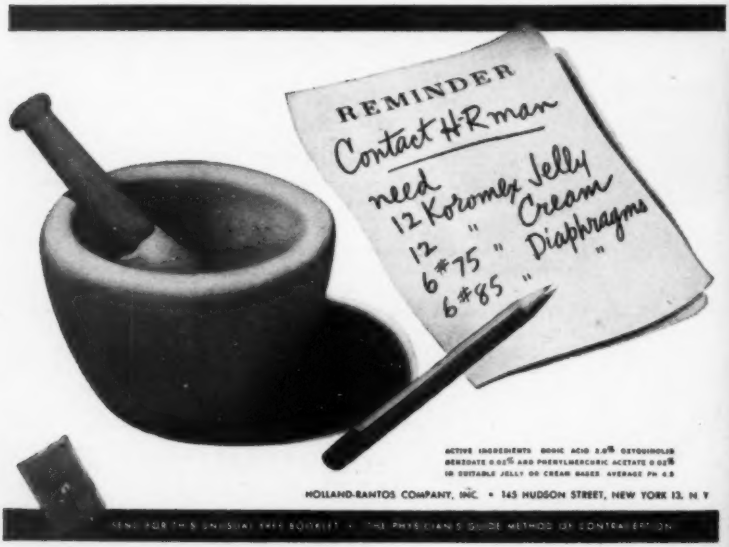
came into my office in a fury. He was a musician who had just returned from Europe to learn that, in his absence, his wife had become a mother—which he anticipated—but that she had given up her child for adoption. 'I want my baby back,' he told me, with great emphasis, 'and I'll spend the rest of my life getting it.'

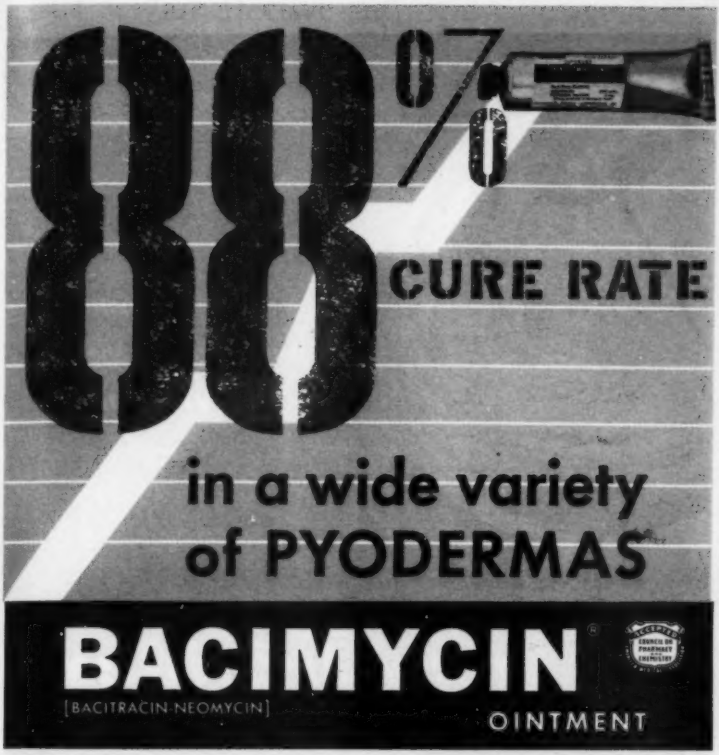
"My investigation revealed that the mother had come from the South to a New York doctor. Picturing herself as an unmarried girl in trouble, she begged his help. The doctor, like every doctor, knew a couple who desperately wanted a baby and who, he felt, were fully capable of taking care of one. So, wanting to do a good deed, he consulted a lawyer, and the necessary adoption arrangements were completed.

"When I told the doctor of the existence of a slight legal complication in the form of an irate husband, he was flabbergasted. 'My God,' he said, 'she wept all over the office that she could never stand the shame of bringing an illegitimate child into the world. She must have been lying' . . .

"The musician filed a writ and fought in court for his baby. He lost, but today he still vows he will get back his child. And the people who have it wonder if, perhaps some day, he will."

END





a first choice for dual antibiotic therapy

In a recent study[1] of 53 patients with various types of pyodermas, the use of BACIMYCIN Ointment "...resulted in a cure rate of 88%..." and not a single case of sensitization or primary irritation occurred.

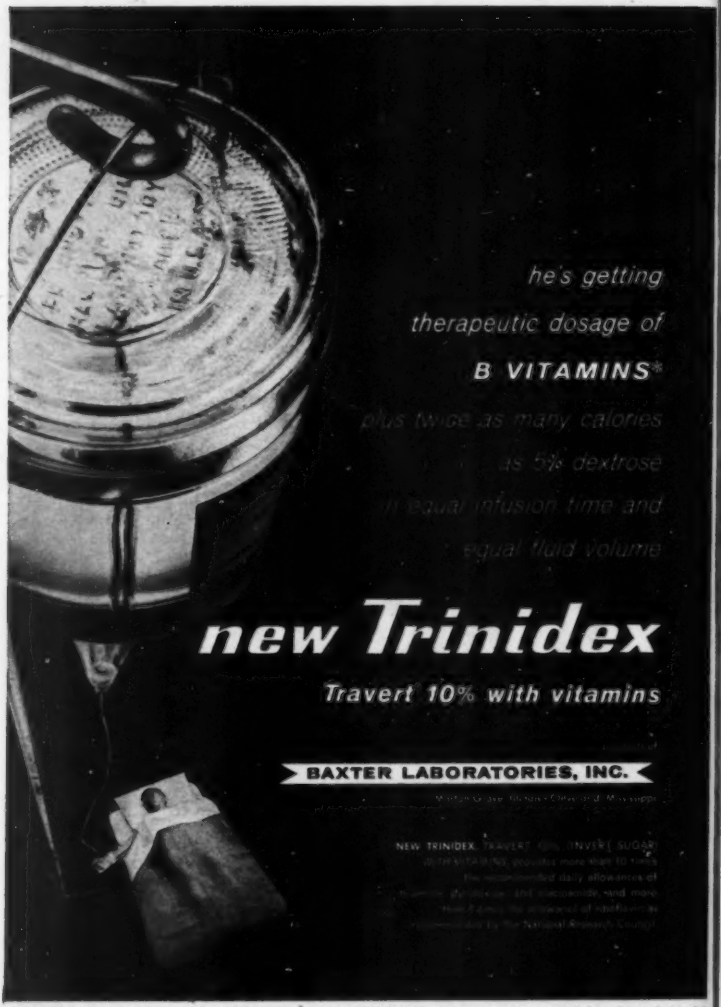
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Supplied in ½-oz. tubes for prescriptions; in 100 gm. jars for hospital use.

Literature and samples on request.

1: Greenhouse, J. M., and Ryle, W. C.: A.M.A. Arch. Dermat. & Syph. 69:366, Mar., 1954.

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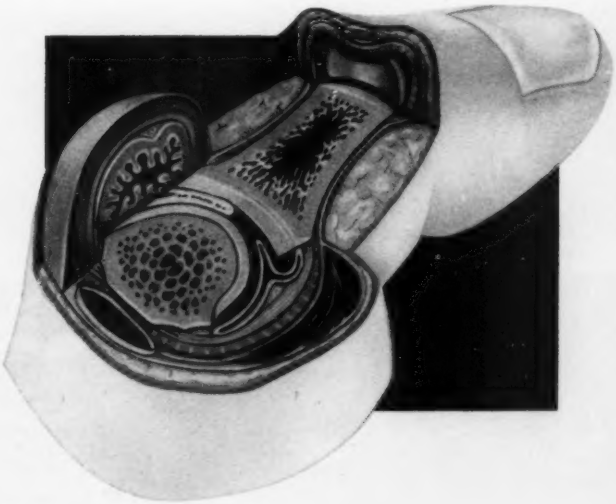
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*Bonin, J. J.: Research Activities in Rheumatic Diseases, Pub. Health Rep. 69:437, 1954.



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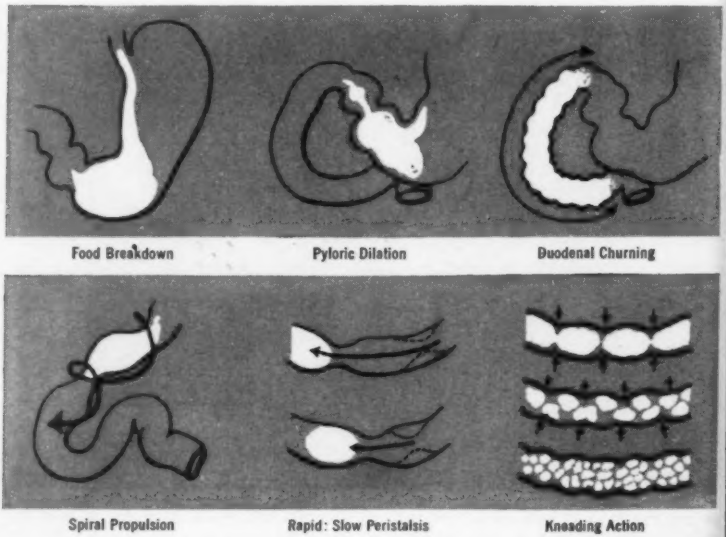
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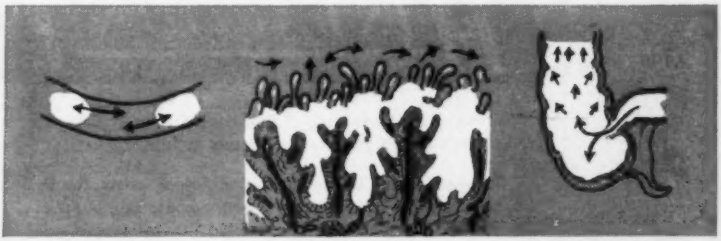


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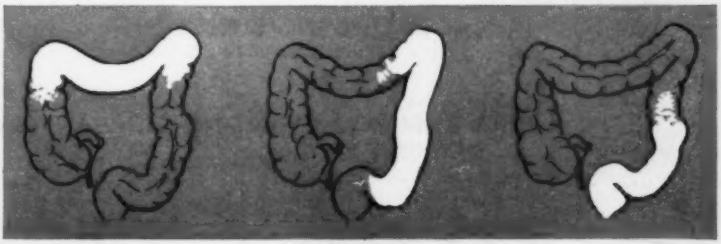
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1. Grayzel, H. G., Helmer, C. B., and Grayzel, R. W.: New York St. J. M. 53:2233, 1953.
2. Helmer, C. B., Grayzel, H. G., and Kramer, B.: Archives of Pediatrics 68:382, 1951.
3. Behrman, H. T., Combes, F. C., Bobroff, A., and Leviticus, R.: Ind. Med. & Surgery 18:512, 1949.
4. Turell, R.: New York St. J. M. 50:2282, 1950.



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IN BRIEF . . .

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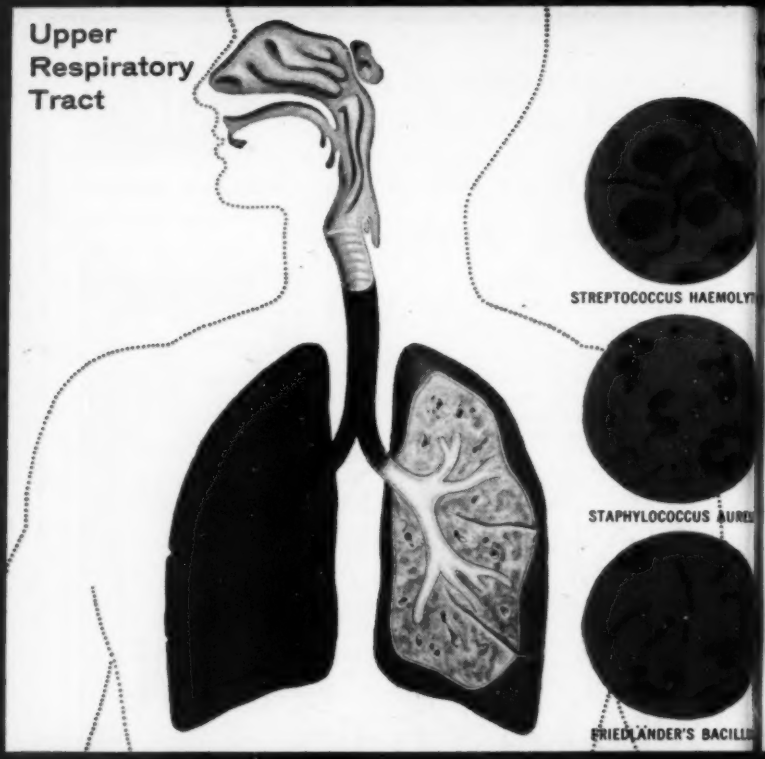
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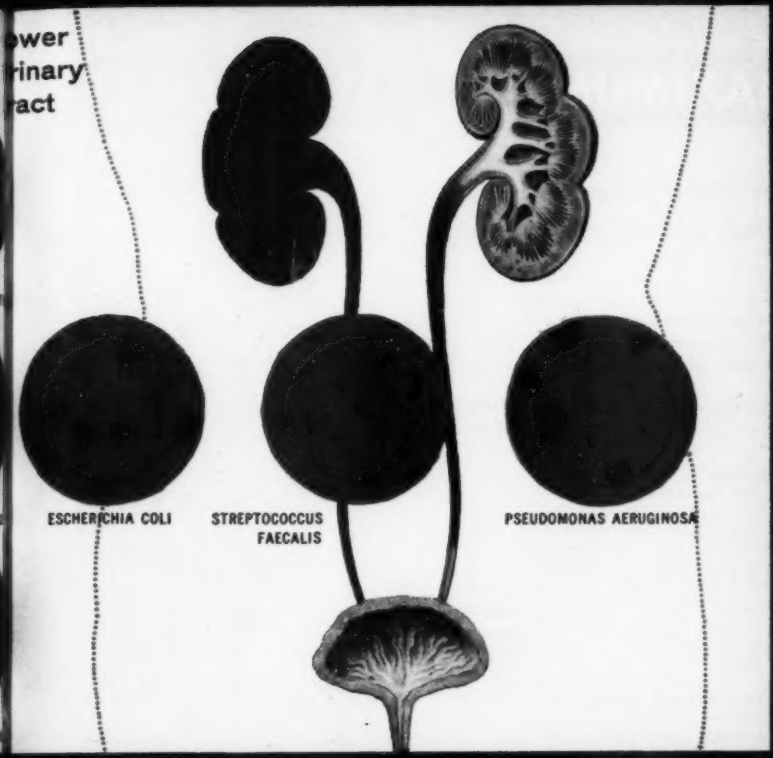
Infections of the upper respiratory or lower urinary tract are commonly associated with mixed bacterial pathogens. Combination therapy is the logical approach.[1,2]

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1. Daly, J.W.: Antibiot. & Chemo. *4*:687 (June) 1954. 2. Spink, W.W.: J.A.M.A. *152*:585 (June 13) 1953.

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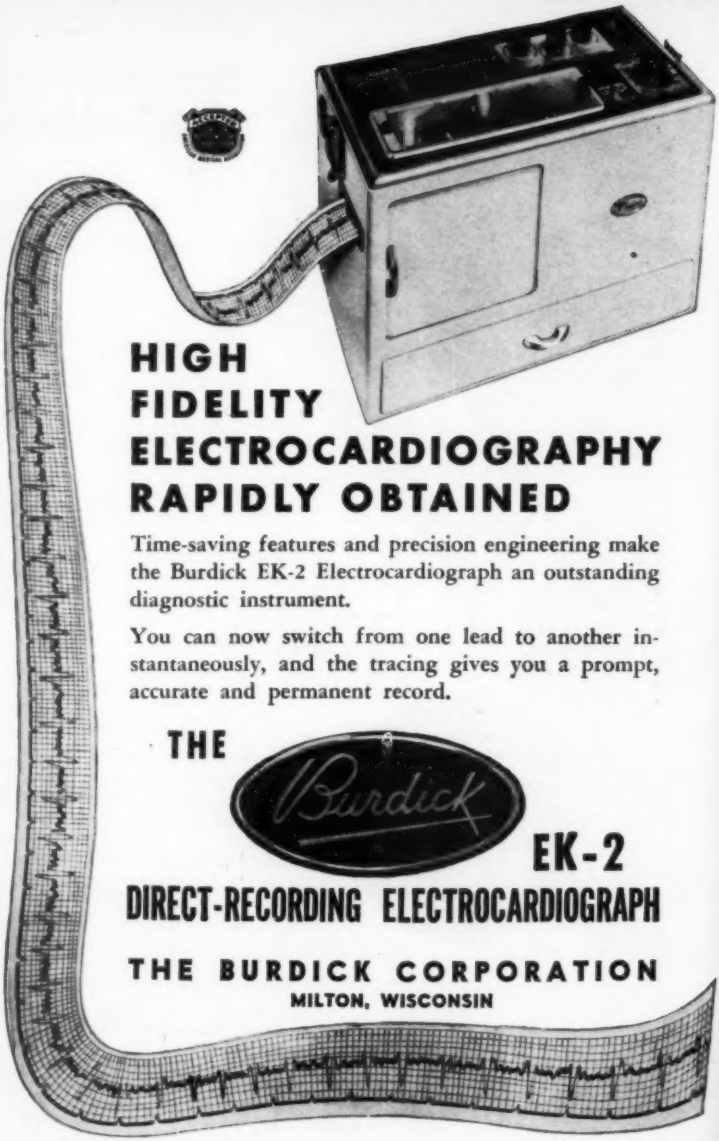
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four reports

attesting to the safety of

'Dexedrine' Sulfate in

obese hypertensives

1

Goodman and Housel (the latter is chief of the Jefferson Hospital Hypertension Clinic, Philadelphia) conducted exhaustive studies of 100 obese hypertensives. They concluded:

- "Prolonged use of oral 'Dexedrine' Sulfate does not affect the long term blood pressure in obese hypertensive patients."
- "'Dexedrine' consistently reduces the appetite . . . "

Goodman, E.L., and Housel, E.L.: Am. J. M. Sc. 227:250 (March) 1954.

2

"There is no apparent effect on hypertension, and the drug can be used freely in hypertensives with obesity . . . "

Finch, J.W.: J. Oklahoma M.A. 40:119.

3

'Dexedrine' "has been given in the cases where the blood pressure was over 200 systolic and 100 diastolic without any ill effects, and [many of] these patients have obtained . . . a drop in blood pressure."

Ferguson, H. E.: Virginia M. Monthly 76:222

4

Livingston, after treating a series of 49 patients with 'Dexedrine' for 1-5 years reported that the blood pressure remained "essentially unchanged throughout the course of the treatment."

Livingston, S.; Kajdi, L., and Bridge, E.M.: J. Pediat. 32:490.

Dexedrine* Sulfate

dextro-amphetamine sulfate, S.K.F.

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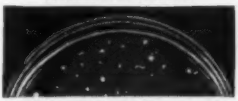


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4. *Helps skin disorders* by destroying bacteria that often spread and aggravate pimples, surface blemishes.

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Letters

What M.D.s can learn from 'false-alarm' calls • Specialty boards scored as too exclusive • Getting a start in industry • Should medical schools favor doctors' sons? • G.P.s refute specialist's criticism

Clinic Pharmacies

SIRS: As executive secretary of the American College of Apothecaries, I cannot agree with the views quoted in your recent news item, "M. D. Stanchly Defends Clinic Pharmacies.". . . It has been our experience in studying clinic pharmacies and similar arrangements that in many cases the patient is not properly protected: He sometimes gets not what the physician believes to be the best drug, but one on which the clinic is perhaps overstocked or on which it makes a higher profit . . .

Where the physician benefits directly from the writing of a prescription, there's an undesirable atmosphere that may result in harm to the patient.

Robert E. Abrams
Philadelphia, Pa.

Reminder Methods

SIRS: I was shocked to read in your January issue that a MEDICAL ECONOMICS survey finds two out of three physicians agreeing that it's "ethical and desirable" to send reminder notices to patients.

To my mind, sending reminders is the kind of high-pressure tactic justifiably used by a salesman, perhaps, but not by a doctor. No matter how you slice it, it's deliberate solicitation of business.

As for the means of notification, a telephone call (preferred by most doctors, according to your findings) seems to me in the worst possible taste. A card signed by the secretary at least has the virtue of being comparatively impersonal.

M.D., New Jersey

As our article pointed out, a number of doctors would agree wholeheartedly with the writer of this letter. Yet reminder notices have long been considered ethical in most parts of the country. They've even been specifically endorsed by some local medical societies. So, except in the rare locale where such notices are officially frowned on, the individual physician may use them if he sees fit. Any reminder notice that's good

for the patient, we say, is good also for the doctor. —ED.

SIRS: Congratulations on your fine article. For many years we have been advising our clients to send follow-ups . . .

But we do recommend that the patient be *asked* whether he'd like to be reminded when his next check-up is due. We believe that as long as he's given a choice, sending such a notice is entirely ethical . . .

Perhaps your readers would also be interested in a simple method for keeping "recall" records:

All the doctor needs is a small file box for 3" x 5" cards, with guide cards labeled for each month of the year. A card noting the patient's name, address, and telephone number, together with the date of his last visit, is filed under the month when he is to be recalled. It's a simple matter, then, for the aide to pull the card at the proper time and call or write the patient.

Millard K. Mills
Professional Management
Waterloo, Iowa

SIRS: I have been sending reminders for seven years. In general, I find my patients appreciate my effort to practice preventive medicine. But I never send a notice without the patient's prior approval.

Melvin V. Warhaftig, M.D.
Springfield, Mass.

SIRS: . . . I've found that when the doctor asks patients to telephone him a week or so after a visit, they rarely do so. Many of them apparently feel that a call to report improvement is an imposition on a busy physician. . .

So in every case where a return visit isn't definitely indicated, I give the patient a stamped, addressed envelope, asking him to mail me a brief progress report. He's usually pleased when I tell him, "It'll burn a hole in your pocket if you don't mail it." And since most people are reluctant to destroy a stamped envelope, I get a high rate of returns.

This system cuts down on telephone calls, which are time-consuming and unsatisfactory—especially if the patient seeks advice on a complex problem. And if the patient's letter contains a dozen or so questions, he rarely resents a tactful suggestion that he return for another interview.

Other advantages: The patient's written report often becomes a valuable addition to his clinical record. And he's usually impressed by the physician's genuine interest in his progress.

Mason Trowbridge Jr., M.D.
Ellsworth, Me.

What's an Emergency?

SIRS: I notice in your pages that doctors continue to voice complaints about being called out for emergencies that, in their view, are no more than "false alarms."

Such complaints puzzle me. They seem to imply (1) that the physi-

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cian expects the patient to make his own diagnosis; and (2) that an emergency is only a situation in which structural damage or a physiological crisis is at hand.

Obviously, most patients call a doctor because they're in physical or emotional distress. The very fact that the patient is suffering means that he's in no position to decide what may or may not be an emergency. What he wants more than anything else is relief and reassurance. He wants to know what he *doesn't* have, as well as what he does have . . .

Another thing: I'm not sure that our usual definition of an emergency is valid. Many of us have seen patients with really dangerous conditions who haven't complained at all. Doesn't this suggest the need for a little more self-evaluation on the part of our profession?

Wilbur R. Miller, M.D.
Iowa City, Iowa

SIRS: . . . As a psychiatrist who has had his share of experience with general practice night calls, I feel that the "false alarm"—nuisance though it may be—offers an excellent opportunity for psychiatric case finding. The patient who calls a physician in the middle of the night for a seemingly trivial complaint is, almost by definition, emotionally disturbed . . . [MORE ▶




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The doctor who finds himself on a night call that isn't warranted by the patient's physical condition should remember that he may be dealing with an emotional illness as serious as any medical emergency, and that his presence and reassurance may be vital to the patient at that moment . . .

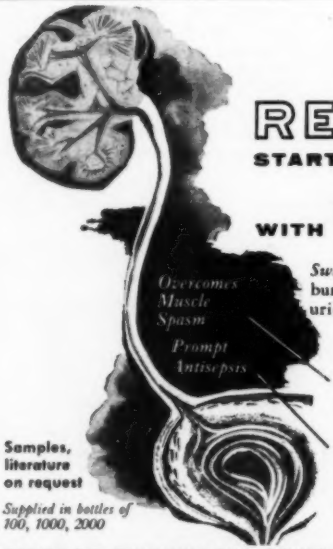
Gerald F. Jacobson, M.D.
Beverly Hills, Calif.

'Elite' Boards

SIRS: There is no question that the specialty boards have raised medical training standards in the United States. But they aren't always satisfied with that. They set themselves up, at times, as an elite corps of "better-than-thous." For example:

Some years ago, I was refused a chance to take the American Board of Surgery exam because I'd been honest enough to say that less than 80 per cent of my practice for two years had been surgical. A decade later, as chief of the surgical services of a 2,700-bed Army hospital, I was again refused a chance to take the exam because I'd made an honest answer years earlier. Yet by then I'd had over four years of surgical residency, I had an M.S. in surgery, and I was a Fellow of both the American College of Surgeons and the International College of Surgeons.

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because of some experience in general practice. But many doctors *do* suffer from too early specialization. Despite this, the American Board of Surgery totally condemns those who have not done surgery exclusively throughout their medical practices.

M.D., Montana

Practice in Industry

SIRS: After rereading your June, 1954, article, "Getting a Start in Industrial Practice," I've been wondering about this sentence: "You can persuade the management of a plant that has no organized medical program to establish one."

As I understand it, this means going to a plant and "selling" the management. Wouldn't such an approach be tantamount to soliciting business—and, therefore, unethical?

Anthony M. Puleo, M.D.
Cleveland, Ohio

Not if the doctor went about it the right way. To quote from our article again: "[The physician] should arm himself with all available ammunition on the value of plant medical programs and . . . concentrate on pointing out how a well-organized program can cut down on accident ratios, absenteeism, and so on."

In other words, he should try to convince the company of the need for protecting employes' health and



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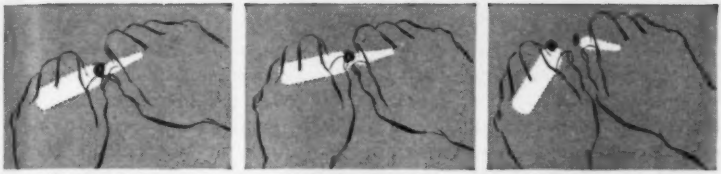
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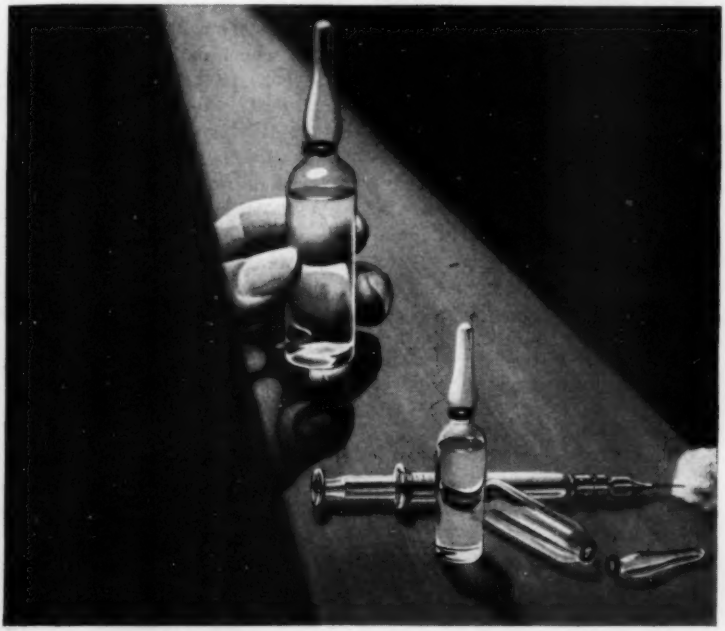
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safety. Indeed, it's his duty to do this, just as it's the duty of an ophthalmologist, say, to encourage periodic eye check-ups. (Of course, in discussing an industrial health program, the doctor would be careful not to imply that he *is better qualified for the job than any other M.D. Any effort to sell himself as a doctor rather than to sell the idea of industrial medicine would obviously be unethical solicitation.)* —ED.

Doctors' Sons as M.D.s

SIRS: According to a recent news item, Dr. Irving J. Sands deplores the fact that doctors' sons often have a hard time getting into medical school. The average such youngster, he argues, has been raised in an atmosphere that should serve to make him a better doctor than most other young men. I disagree.

I have sat long enough on the admissions committee of the Tulane University School of Medicine to see boys whom I helped admit later finish school and enter practice. So far, I haven't detected any clear superiority of doctors' sons, either as students or as young practitioners.

Nevertheless (and contrary to Dr. Sands' impression), most medical schools look with great favor on well-qualified applicants from medical families. Physicians' sons make up 13 per cent of our present student body at Tulane, whereas phy-

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*Tainter, M. L., et al: Papain, Ann. New York Acad. Sc. 54:143-296 (May) 1951.



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sicians constitute only 0.13 per cent of the general population.

Even so, we have learned the hard way that a medical home environment is no substitute for a good academic and personal record . . .

Charles E. Dunlap, M.D.
New Orleans, La.

In Defense of G.P.s

SIRS: This is in answer to the tirade that appeared in your Letters department recently, signed "M.D., Texas." Only an internist, said the writer, is capable of being a good family doctor.

How come? I ask. Doesn't the internist's very certification limit his practice? . . .

According to this Texan, the G.P.s are beating "the publicity drum for a return to medical mediocrity." Yet the fact is that the American Academy of General Practice requires its members to put in 150 hours of post-graduate study every three years. No specialty board I know of has such a rule.

There are three fundamental requisites for good medical practice that "M.D., Texas" didn't get with his certification: mellowness, maturity, and common sense.

J. Edwin Reed, M.D.
Cincinnati, Ohio

SIRS: That board-certified specialist from Texas could not have written a letter more revealing of his shortcomings . . . All of us have known men who, because of such shortcomings (and despite good educations), could not possibly make a living. There is only one place for these misfits: in the research laboratories . . .

Clenton Whitehurst, M.D.
Auburndale, Fla.

SIRS: . . . There are no G.P.s who won't admit that some of their number get in over their heads. But I'm quite sure that the ratio of honest to dishonest men in general practice is no worse than in the specialties . . .

T. M. Trimble, M.D.
Fort Worth, Tex.

SIRS: . . . When a man is chosen for a residency in surgery (or in some other specialty), little importance is attached to his native abilities. Later on, there is great reluctance to discharge a resident who seems to lack skill or judgment. Result? A fair number of men who can, at best, be termed "inadequate" complete their residencies and become board-certified specialists . . .

I know two "qualified" specialists who took resident surgical training after—and *because*—they'd failed two or three times in general practice. So it seems to me that just as much weight should be given to a man's native talents, and to his inherent honesty, as to his paper credentials. It is no less ridiculous to say that all specialists excel than that all G.P.s are mediocre . . .

M.D., Michigan

END

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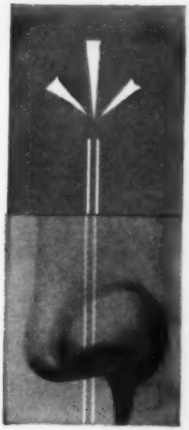
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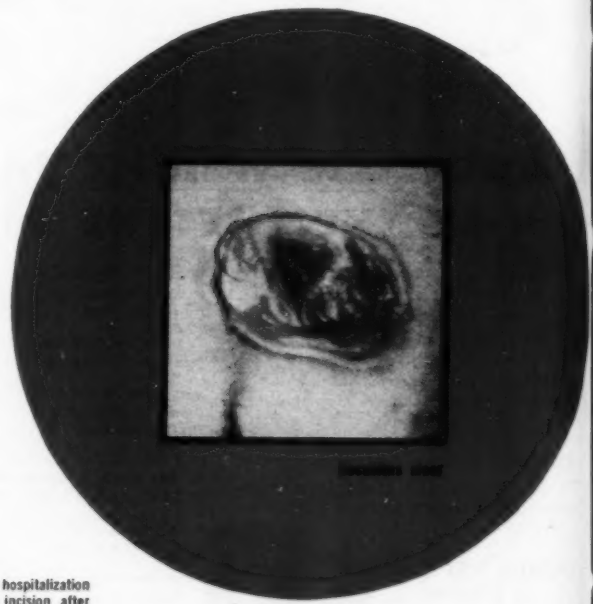
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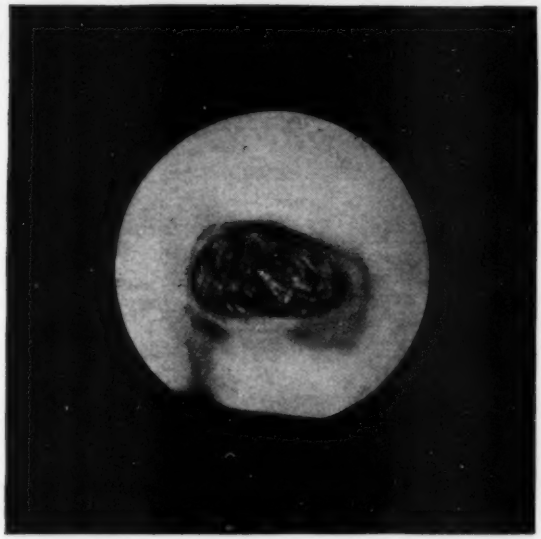
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Ophthalmic disorders
iritis
iridocyclitis
chorioretinitis

IMPORTANT CLINICAL REPORTS:

Innerfield, I., *Trypsin Given Intramuscularly in Chronic, Recurrent Thrombophlebitis, J.A.M.A.*, 156:1056-1058 (Nov. 13) 1954.

Golden, H., *Intramuscular Trypsin, Its Effect in 83 Patients with Acute Inflammatory Disorders, Del. State Med. J.*, 26:267-270 (Oct.) 1954.

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This is only the beginning, but it gives your patient something to start with. Before long he'll want to experiment for himself. And while he's learning new flavor tricks, your treatment has a chance to show its full effectiveness.



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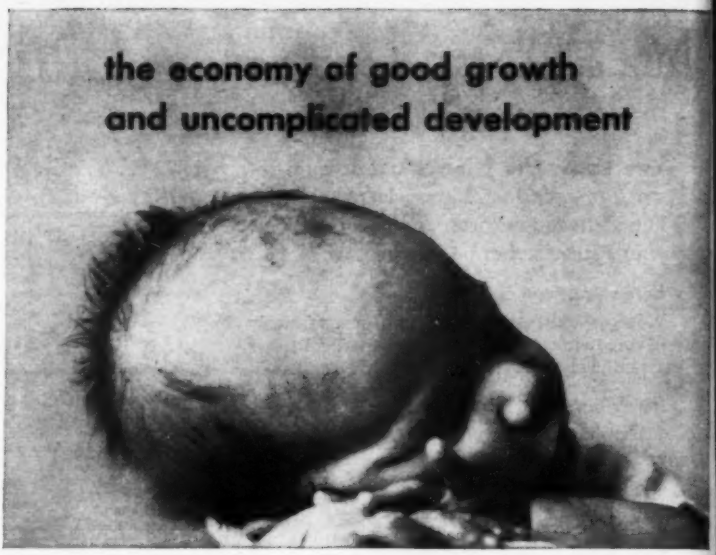
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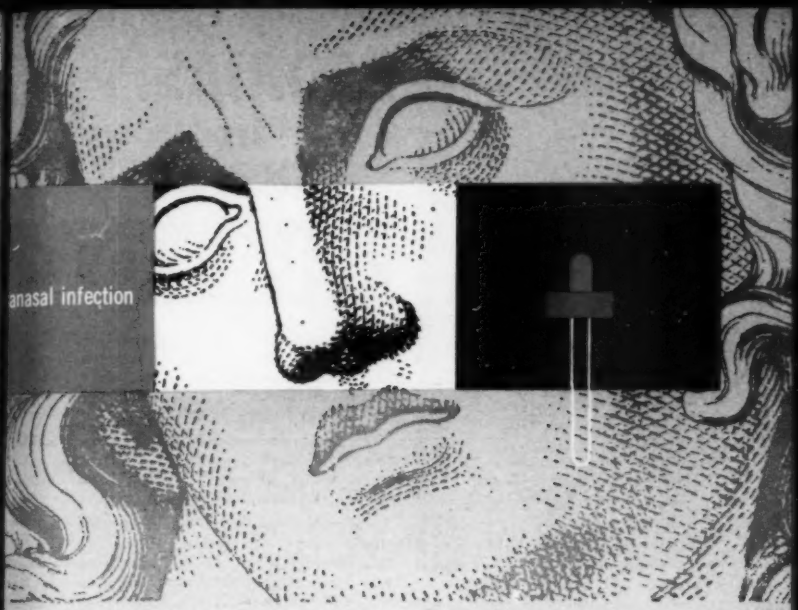
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1. Winsor, T., and Humphreys, P.: Angiology *3*:1 (Feb.) 1952. 2. Plotz, M.: New York State J. Med. *52*:2012 (Aug. 15) 1952. 3. Dailheu-Geoffroy, P.: L'Ouest-Médical, vol. 3 (July) 1950.

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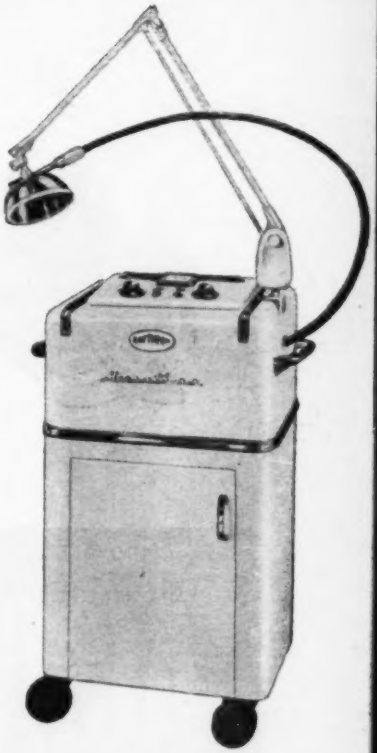
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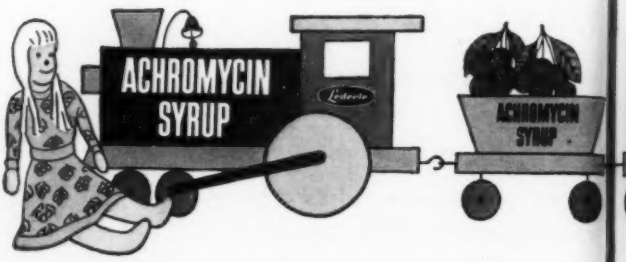
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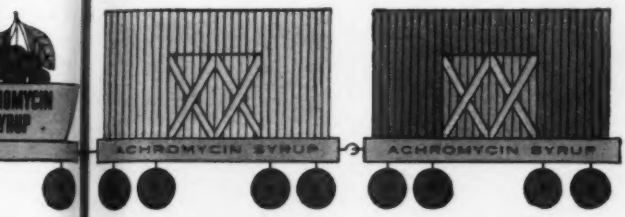
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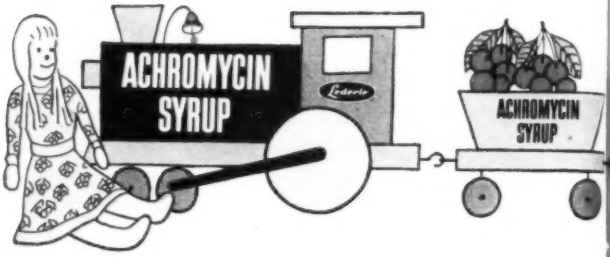
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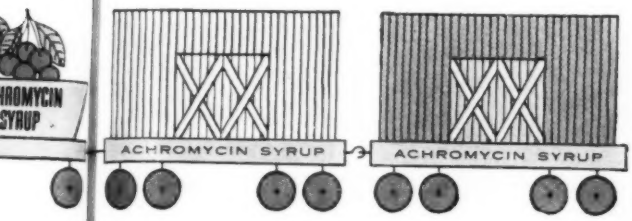
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ACHROMYCIN broad-spectrum • rapid diffusion • prompt control of infection • well tolerated • effective against Gram-positive and Gram-negative bacteria, rickettsiae, spirochetes, and certain viruses and protozoa.

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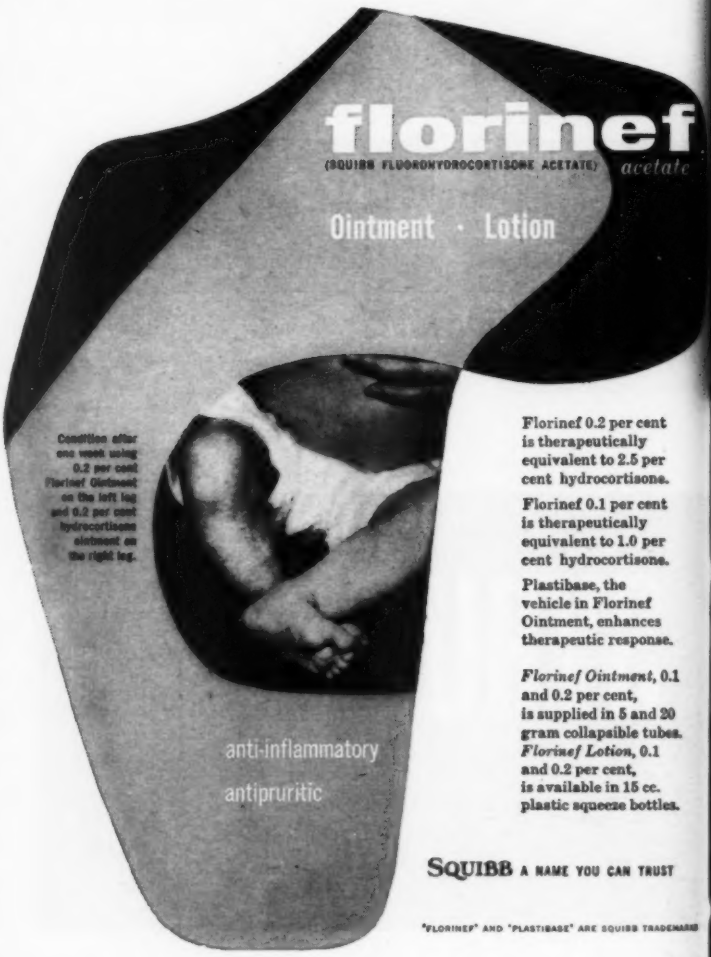
in dermatologic conditions...

two new and potent corticoid preparations

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(SQUIBB FLUORONYDROCORTISONE ACETATE) *acetate*

Ointment · Lotion



Florinef 0.2 per cent is therapeutically equivalent to 2.5 per cent hydrocortisone.

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Plastibase, the vehicle in Florinef Ointment, enhances therapeutic response.

***Florinef Ointment*, 0.1 and 0.2 per cent, is supplied in 5 and 20 gram collapsible tubes. *Florinef Lotion*, 0.1 and 0.2 per cent, is available in 15 cc. plastic squeeze bottles.**

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"FLORINEF" AND "PLASTIBASE" ARE SQUIBB TRADEMARKS



from pain to productivity

Acetycol brings quick and effective relief to the patient suffering from arthritis, osteoarthritis, acute or chronic gout, and related rheumatoid disorders. As Acetycol increases the range of pain-free movement, the patient is able to resume a more normal, satisfying and productive life.

The prompt, sustained effect of Acetycol is due to a synergism between aspirin and para-aminobenzoic acid. High salicylate blood levels are attained with relatively low dosage. The addition of salicylated colchicine extends the effectiveness of Acetycol to gout or cases of a gouty nature.

Acetycol contains three important vitamins often deficient in older and rheumatic patients: these are ascorbic acid for prevention of degenerative changes in connective tissues; and thiamine and niacin for carbohydrate utilization and relief of joint pain and edema.

Each Acetycol tablet contains:

Aspirin	325.0 mg.
Para-aminobenzoic acid	162.0 mg.
Colchicine, salicylated	0.25 mg.
Ascorbic acid	20.0 mg.
Thiamine hydrochloride	5.0 mg.
Niacin	15.0 mg.

Supplied: Bottles of 100 and 500.

Acetycol

TRADEMARK

to relieve rheumatic pain

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Terra·Cortril

brand of oxytetracycline and hydrocortisone

topical ointment

when the dermatologic picture is due to double exposure



Terra·Cortril Topical Ointment rapidly clears both underlying inflammation and superimposed infection, through the combined actions of CORTRIL®—most potent anti-inflammatory adrenocortical steroid; and TERRAMYCIN®—"perhaps the most effective antibiotic in pyogenic skin diseases."[2]

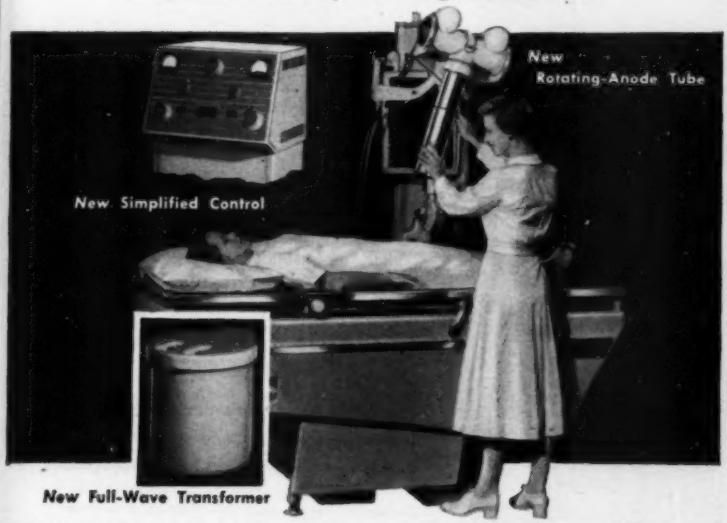
supplied: In 1/2-oz. tubes containing 3% TERRAMYCIN (oxytetracycline hydrochloride) and 1% CORTRIL (hydrocortisone, free alcohol) in a specially formulated, easily applied ointment base. **also available:** CORTRIL Topical Ointment and CORTRIL Tablets.

1. Rukes, J. M., et al.: Metabolism 3:481, 1954.
2. Peterkin, G. A. G.: Brit. M. J. 1:522, 1954.

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Now! G-E offers you a 200-ma x-ray unit for only $4900

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YOU don't have to be handicapped by under-powered, inflexible x-ray apparatus. General Electric not only gives you the Maxicon ASC — *a full length table of rigid construction* — but also offers you all this for complete fluoroscopic and radiographic facilities: a new simplified 200-ma control unit . . . a new lightweight rotating-anode tube . . . a new full-wave x-ray transformer.

That $4900 price includes, in addition, electronic timing, 1/20 to 10 seconds . . . 8:1 Bucky diaphragm . . . and fluoroscopic screen. Available at extra cost are motor-drive table angulation, spot-film device and 16:1 Bucky diaphragm.

Now's the time to step up your radiographic facilities. And, remember, you can get the Maxicon ASC — without initial capital investment — on the G-E Maxiservice® rental plan. For facts, see your G-E x-ray representative, or write X-Ray Department, General Electric Company, Milwaukee 1, Wis., for Pub. C-41.

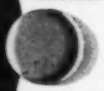
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A really new prenatal supplement

new because—

- ***chelated iron***...for exceptional tolerance
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- plus 10 other essential metabolites important in pregnancy



Chelated iron...better tolerance...iron is not suddenly imposed on the duodenum and upper jejunum... hence, no irritation...***better uptake***...iron is available over an extended area of the gastrointestinal tract.

Phosphorus-free calcium...avoids the neuromuscular complaints attributed to phosphorus-containing calcium supplements.

Ferrolip OB dosage is small. Just 1 tablet t.i.d. provides:

Ferrolip* (Iron Choline Citrate)	150 mg.
Tricalcium Citrate	600 mg.
Calcium Gluconate	300 mg.
Thiamine Mononitrate	3 mg.
Riboflavin	3 mg.
Niacinamide	30 mg.
Calcium Pantothenate	10 mg.
Pyridoxine Hydrochloride	10 mg.
Ascorbic Acid	200 mg.
Folic Acid	0.5 mg.
Vitamin B_{12} with Intrinsic Factor Concentrate 1 U.S.P. Unit (Oral)	
Vitamin A	5000 Units
Vitamin D	500 Units

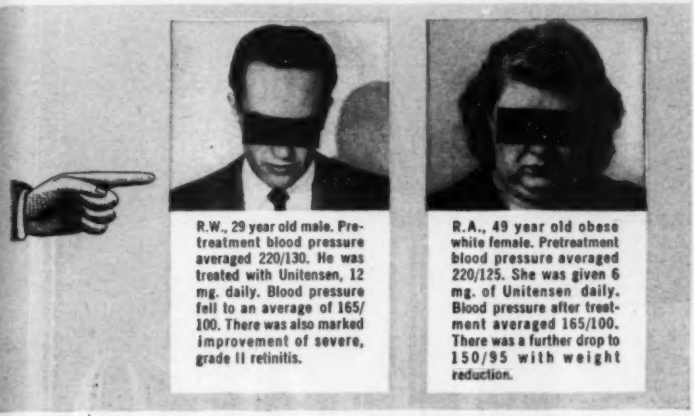
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IN HYPERTENSION GIVES YOU RESULTS LIKE THESE...



R.W., 29 year old male. Pretreatment blood pressure averaged 220/130. He was treated with Unitensen, 12 mg. daily. Blood pressure fell to an average of 165/100. There was also marked improvement of severe, grade II retinitis.

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Unitensen represents the latest research development in hypertension. It contains cryptenamine tannate—a synthesized salt of a newly isolated ester alkaloid fraction never heretofore made available.

Unitensen is a true anti-hypertensive agent that decisively controls arterial hypertension. It dependably lowers blood pressure in the majority of patients without ganglionic blocking. It is free from dangerous side actions. Dosage is uncomplicated. Economical Unitensen saves your patients ⅓ to ½ over the cost of other potent hypotensive agents.

the most dependable agent you can use to lower blood pressure

UNITENSEN® tannate tablets

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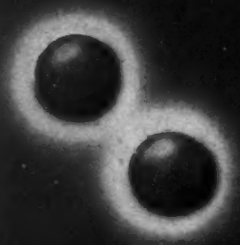
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Complete **2-A-DAY** therapy
for iron-deficiency, nutritional
and pernicious anemias

*T.M. for Abbott's film-sealed tablets, pat. applied for.



new IRON-PLUS formula

The right amount of iron
+
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+
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For iron-deficiency, nutritional and pernicious anemias



new SMALLER size

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Dosage supply lasts 50% longer than 3-a-day treatment

new Iberol®

filmtab

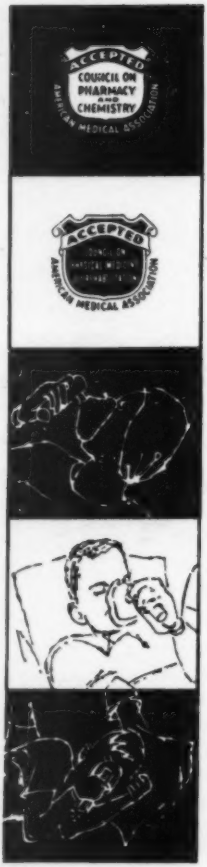
2 IBEROL *Filmtabs contain:*

Elemental Iron (*as Ferrous Sulfate*)	210 mg.
+	
BEVIDORAL® (*Vitamin B_{12} with Intrinsic Factor Concentrate, Abbott*)	1 U.S.P. Oral Unit
+	
Folic Acid	2 mg.
Ascorbic Acid	150 mg.
Liver Fraction 2, N.F.	200 mg.
Thiamine Mononitrate	6 mg.
Riboflavin	6 mg.
Nicotinamide	30 mg.
Pyridoxine Hydrochloride	3 mg.
Pantothenic Acid	6 mg.

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FOR SELF-ADMINISTERED INHALATION ANALGESIA



"Trilene"®

Brand of trichloroethylene U.S.P. (Blue)

"Duke"® University Inhaler

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in obstetrics and minor surgery

notably safe and effective

"Trilene," self administered with the "Duke" University Inhaler, under proper medical supervision, provides highly effective analgesia with a relatively wide margin of safety. Induction is usually smooth and rapid with minimum or no loss of consciousness. If unconsciousness occurs, inhalation is automatically interrupted. Nausea and vomiting seldom occur. Recovery is rapid.

"Trilene" is now accepted by the Council on Pharmacy and Chemistry of the American Medical Association.

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The "Duke" University Inhaler (Model-M) is specially designed for economy, facility of handling, and ready control of vapor concentration. The patient treated on an ambulatory basis in the physician's office or the hospital can usually leave within 15 to 30 minutes.

The "Duke" University Inhaler is now accepted by the Council on Physical Medicine and Rehabilitation of the American Medical Association.

"Trilene" alone is recommended only for analgesia, not for anesthesia nor for the induction of anesthesia. When using "Trilene" in conjunction with anesthetic agents (as an analgesic adjunct), standard machines may be employed provided they are adjusted so that "Trilene" *is not used in a closed circuit with soda lime.* Epinephrine is contraindicated when "Trilene" is administered.

"Trilene" is available in 300 cc. containers, 15 cc. tubes, and 6 cc. ampuls.

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5515

Editorials

Why the case for reinsurance has yet to be proved • Organized medicine needs more 'Young Turks' • Which items on your tax return are most likely to be challenged? • More time off makes economic sense

Reinsurance Revisited

Just about a year ago, President Eisenhower threw his weight behind Federal reinsurance of the voluntary health plans. The idea was to protect such plans against "abnormal losses" while they experimented with broader coverage and marginal risks. "In this way," the President thought, "we can compress the experimentation of the next twenty years into less than half the time."

Commenting editorially on the President's proposal, this magazine found it laudable in principle, although somewhat fuzzy in detail. We resolved the unanswered questions in favor of the scheme. Thus:

"Would it act as a safe yet useful bulwark against abnormal losses, as the Federal Deposit (bank) Insurance Corporation does? Or would it turn out to be an outright Government-subsidy scheme in disguise? It now appears that straight reinsurance is the Administration's aim. . .

"Of course, the reinsurance plan is no panacea . . . Nevertheless, [it] does give the impression of being a needed step in the right direction . . . a sensible approach to the still-unresolved problem of broadening the health insurance base."

Today, a year later, we still regard reinsurance as a sensible approach. But we can no longer disregard the unanswered questions about it. Especially these:

¶ Is there a demonstrable need for reinsurance beyond what private reinsurers can provide?

¶ Is there evidence that voluntary health plans would actually use a Federal reinsurance service?

¶ Are there grounds for thinking that such a service, specializing in bad risks, could remain actuarially sound?

¶Are there safeguards that would prevent some future Secretary of Health, Education, and Welfare from misdirecting the very great regulatory powers he'd have?

There may be positive answers to questions like these; but so far the sponsors of reinsurance haven't

spelled them out. Until they do, we're forced to conclude that the case for reinsurance hasn't been proved. (Nor, we might add, has the case against it.)

This year's reinsurance proposal* is more specific than last year's. For example, it now stakes out the exact areas in which experimentation should be encouraged. In the President's own words, these areas are: "protection against the high costs of severe or prolonged illness . . . coverage for individuals and families in predominantly rural areas . . . coverage of individuals and families of average or lower income . . ."

This year's bill even specifies the minimum benefits that reinsured plans must provide (service plans: at least seventy days' hospital care a year; indemnity plans: at least 85 per cent of hospital costs, at least 75 per cent of medical-surgical costs).

If we physicians hold our discussion to an equally specific level—and if insurance men and Government people follow our lead—the next few months may bring a decisive answer to the question: Is reinsurance practical or not?

Young Turks

In psychiatry some years ago, older men dominated the specialty. Then a group of self-styled "Young Turks" rebelled. They moved in on

*As embodied in S. 886, sponsored by Senator H. Alexander Smith (R., N.J.), and in H.R. 3458, sponsored by Representative J. Percy Priest (D., Tenn.).

Rx INFORMATION

BENTYL

Bentyl affords direct (musculotro and indirect (neurotropic) spas lytic action. Bentyl provides c plete and comfortable relief smooth muscle spasm; particul in functional G.I. disorders, in table colon, pylorospasm, bil tract dysfunction and spastic c stipation.

Composition: Each capsule teaspoonful (5 cc.) contains 10 of Bentyl (dicyclomine hydroc ride).

Bentyl with Phenobarbital 15 mg. of phenobarbital to preceding formula.

Dosage: *Adults* — 2 capsules 2 teaspoonfuls of syrup, three t daily, before or after meals necessary, repeat dose at bedt *In Infant Colic* — ½ to 1 teaspo ful, ten to fifteen minutes bef feeding.

Supplied: Bentyl — In bottles 100 and 500 blue capsules, Bentyl Syrup in pint and gal bottles. Bentyl with Phenobarbi — In bottles of 100 and 500 blu and-white capsules, and Ben Syrup in pint and gallon bott

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nervous
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Composition: Each capsule or teaspoonful (5 cc.) contains 10 mg. of Bentyl (dicyclomine hydrochloride).

Bentyl with Phenobarbital adds 15 mg. of phenobarbital to the preceding formula.

Dosage: *Adults* — 2 capsules or 2 teaspoonfuls of syrup, three times daily, before or after meals. If necessary, repeat dose at bedtime. *In Infant Colic* — ½ to 1 teaspoonful, ten to fifteen minutes before feeding.

Supplied: Bentyl — In bottles of 100 and 500 blue capsules, and Bentyl Syrup in pint and gallon bottles. Bentyl with Phenobarbital — In bottles of 100 and 500 blue-and-white capsules, and Bentyl Syrup in pint and gallon bottles.



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"M. 'BENTYL'"

the long and short of Bentyl's relief of nervous gut



Clinicians[1,2] prove Bentyl is long on effective relief... short on unwanted side effects including blurred vision and dry mouth.

1. Kennedy and Bowman: Gen. Med. 3, 43:1139, 1958.
2. Lieber and Shay: Fed. Proc. 12:99, 1953.

Complete Bentyl bibliography on request.

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another exclusive development of Merrell research

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Convenient! Complete!

TUBE-FEEDING FORMULA

supplies essential nutrients for 24 hours!

MIX:

1 qt. whole milk

3 cups (405 Gm.) non-fat milk powder

4 heaping tbsps. (60 Gm.) GEVRAL PROTEIN

Water to make 2,000 cc.

SUPPLIES:

Liquid	2,000 cc.
Protein	217 Gm.
Fat	42 Gm.
Carbohydrate	273 Gm.
Calories	2,354

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GEVRAL* PROTEIN

Geriatric Vitamin-Mineral-Protein Supplement Lederle

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AMERICAN Cyanamid COMPANY Pearl River, New York

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the American Psychiatric Associa tion, breathed new life into its activ ities, even got some of their own group elected as officers. Organized psychiatry has been lively, vigor ous, dynamic ever since.

Would our medical societies ben efit from the same sort of youth movement? In many local areas they already have. But on a national scale there have been few signs of youthful resurgence—until recently.

Now, something's stirring. Young doctors are discovering that they can extend their influence even to the A.M.A. House of Delegates—that venerable institution whose members are mostly over 60.

At their last session, for example, the A.M.A. delegates were pre pared to express their unalterable opposition to an extension of the Doctor Draft. Then representatives of the Medical Veterans Society—22,000 physicians, most of them young—swung into action:

At committee hearings, men in their mid-thirties warned their se nior colleagues against such an in flexible stand. The military situa tion was changing fast, they pointed out; medicine's policy might have to change with it.

Largely as a result, the delegates modified their position. They voted to let the A.M.A. Board of Trustees and the Council on National De fense "handle properly any new sit uation that may develop in regard to this . . . problem."

This small triumph for youth may



in the management of hypertension

The potent autonomic ganglionic blocking action of Methium has now been augmented by the mild hypotensive and sedative properties of reserpine. A true synergistic combination, Methium with Reserpine produces "better hemodynamic stability than when either one is used alone."[1] In one series, more patients obtained adequate blood pressure reduction than from any single drug or combination of drugs previously reported.[1]

Of special significance, a satisfactory response has been achieved with less than half the usual Methium dosage.[2] As a result, "the occurrence and intensity of physiologic side effects were markedly reduced and were minimal and of benign nature."[2]

Because of the potency of Methium, careful use is, nevertheless, required. Precautions are indicated in the presence of renal, cardiac or cerebral arterial insufficiency. Markedly impaired renal function is usually a contraindication.

Supplied: *Methium 125 with Reserpine* — scored tablets containing 125 mg. of Methium and 0.125 mg. of reserpine. *Methium 250 with Reserpine* — scored tablets containing 250 mg. of Methium and 0.125 mg. of reserpine.

1. Ford, R. V., and Moyer, J. H.: Am. Heart J. *46*:754 (Nov.) 1953.

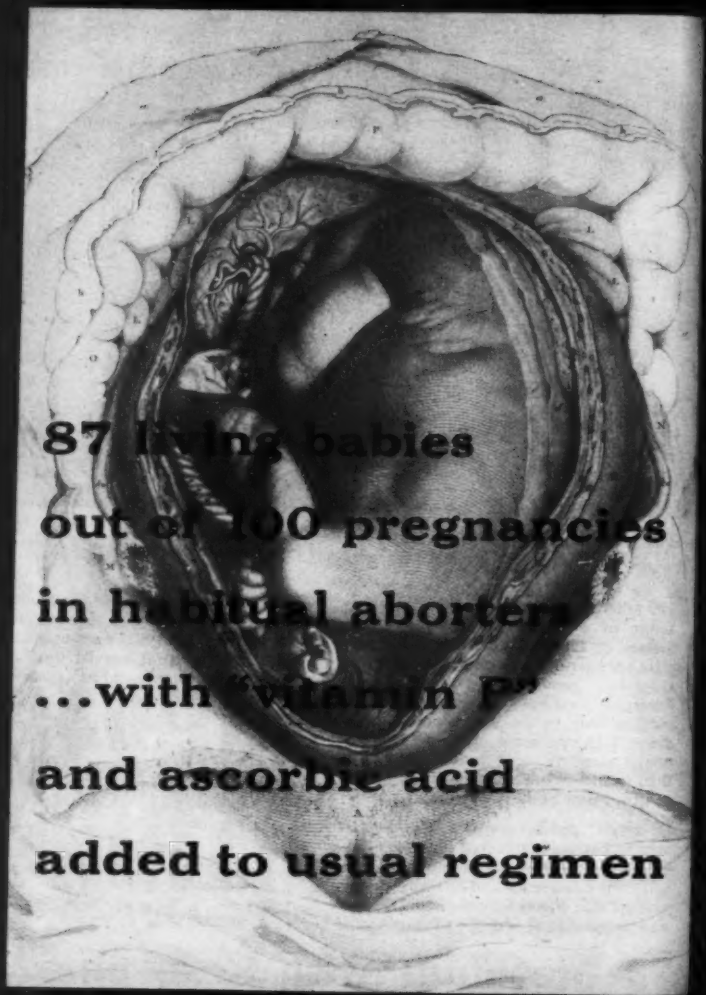
2. Crawley, C. J., *et al.*: New York State J. Med. *54*:2205 (Aug. 1) 1954.

Methium® with Reserpine

CHLORIDE

(BRAND OF HEXAMETHONIUM CHLORIDE)

WARNER-CHILCOTT


87 living babies
out of 100 pregnancies
in habitual aborters
...with "vitamin P"
and ascorbic acid
added to usual regimen

Noting frequent nosebleeds, gum bleeding and bruises in a high percentage of pregnant women who had repeated spontaneous abortions, one investigator added "vitamin P" with ascorbic acid to usual therapy.

results: 87 live infants in 100 pregnancies

Since over 80% of habitual aborters showed capillary fragility in another study, "vitamin P" with ascorbic acid was added to accepted methods of treatment.

results: living baby born to . . . 11 of 13 patients who had had 2 spontaneous abortions each . . . 4 of 7 patients who had had 3 to 8 abortions each

new, simple, safe method of fetal salvage in threatened or habitual aborters . . . strengthens intercellular cement and increases capillary resistance

CVP

Each C.V.P. capsule or each teaspoonful (5 cc.) of syrup provides:

Citrus Flavonoid Compound* . . . 100 mg.
Ascorbic Acid (Vitamin C) . . . . . 100 mg.

*water-soluble, whole natural "vitamin P" complex is more active than insoluble rutin or hesperidin.

rationale: The correction of abnormal capillary fragility in habitual aborters supposedly "decreases the possibility of retroplacental hemorrhage, or possibly enhances the efficacy of established therapeutic regimens by modifying capillary permeability and vascular disturbances throughout the body, whether they be in the skin, liver or the placenta."

samples and literature from **u. s. vitamin corporation**

Arlington-Funk Laboratories, division
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in time be repeated. For more than half of all medical men are under 45 years of age. They have the weight of numbers to make their influence felt.

We'd like to see them exert this influence, and we suspect that the A.M.A. would too. For true democracy in medicine depends on more "Young Turks."

Tax Postscript

Before you stow this season's income-tax records away, better ask yourself one last question: Which items on the return you've mailed in are most likely to be challenged?

We've been collecting opinions on this. Here are the experts' nominations:

1. Entertainment deductions. This is where a tax agent's eye is most likely to light. If your listed outlays for professional entertainment were at all substantial—say, more than 1 per cent of adjusted gross income—you're almost certain to be asked for details.

And what will the T-man want first? Proof that the people you entertained later came to you as patients, or at least referred patients to you. So before you file your canceled checks and receipted bills, see that the names of your guests are written on the backs; and that your appointment book or referral record



tykes don't "take on"
when they take

DIATUSSIN
non-narcotic cough control

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depresses... ...gastrointestinal motility

...gastric acid secretion

...nervousness and irritability so common in the ulcer diathesis



SUPPLIED: Antrenyl-Phenobarbital Tablets (scored), each tablet containing 5 mg. Antrenyl and 15 mg. phenobarbital.

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SIMPLER PATIENT MANAGEMENT

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When ganglionic blockade is called for in rapidly progressing, otherwise intractable hypertension, Rauwiloid + Hexamethonium (each tablet containing 1 mg. Rauwiloid and 250 mg. hexamethonium chloride dihydrate) serves with greater efficacy and greater safety. The combination provides smoother, less erratic response to hexamethonium and permits greatly reduced dosage of the latter drug (up to 50% less). Initial dose, ½ tablet q.i.d. In bottles of 100.

Riker LABORATORIES, INC., LOS ANGELES 48, CALIF.

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shows some of these same names.

2. *Travel deductions.* Tax auditors usually fine-comb all listed outlays for medical meetings at a distance from your home. They're looking for items that might be personal expenses.

Along with your tax records, therefore, you'd better file convention programs, registration lists, and other printed matter that proves the duration and professional nature of your stay. And if your wife accompanied you, keep any available evidence (such as *her* canceled checks) to prove that her expenses were not lumped with yours.

3. *Automobile deductions.* Here, too, the auditors tend to suspect that personal expenses have been included. They're particularly interested in the *proportion* of total operating expenses you claimed.

Be ready with memoranda of professional mileage and total mileage for the year. The relation between these two figures should support the deduction you took.

After April 15, such details may sound like the last straw. Attend to them anyway: They can save you many uneasy hours later on.

Vacation Economics

Three-week vacations are quite common in industry now. But the typical doctor, according to a recent



survey by L. W. Frohlich and Company, takes only two weeks; and one out of five doesn't take any vacation at all.

We wish these doctors could listen to an accountant-friend of ours. This man has seen convincing evidence that the doctor who practices eleven months a year will earn more than the doctor who practices twelve months a year.

How is this possible? Our friend explains it this way:

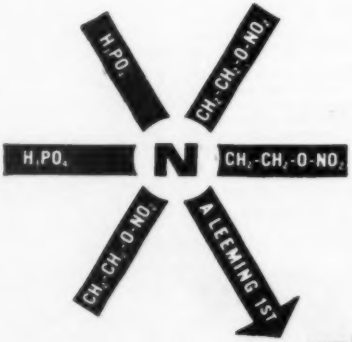
"Well, the vacation-minded doctor lasts longer—and so, of course, does his earning power. He works with greater zest and energy during the months he's working. If he has well-trained assistants in his office, his income isn't cut off completely during his absence. And if he attends a medical convention, as about half do, his vacation costs will be partly tax-deductible."

Whenever longer vacations are suggested, many an M.D. says to himself: "I just can't get away!" For such men, several short vacations a year seem to be the answer. According to the Frohlich survey, one-quarter of all doctors already split their vacations between two seasons or more.

We think this practice will continue to grow. For vacations, no matter how you slice them, make *economic* sense.

—H. SHERIDAN BAKETEL, M.D.

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LESS COST



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If you're not familiar with this ingenious device, ask your surgical dealer to demonstrate.

If you're not acquainted with the many advantages of cryotherapy for removing superficial blemishes, write for literature and reprints.

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*J. A. M. A. 113:296, 1942.

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The G.P. 'Wants In'

And, more and more, he's getting in. But his fight for hospital privileges is a rough one

By Lawrence C. Goldsmith

● The number of hospitals that give G.P.s privileges in their clinical divisions surged from 1,333 in 1950 to 3,251 in 1953. By now the 1950 figure may well have tripled.

It would appear from this that the general practitioner has made spectacular gains. Yet "satisfactory" would be a more accurate word. For the statistics sound rosier than the facts warrant. "Privileges" mean little when hedged round, as they sometimes are, with formal thou-shalt-nots.

Answers to questions asked recently by this magazine of members of the Hospital Commission of the American Academy of General Practice indicate that the nation's family doctors have regained much lost ground in their struggle for hospital privileges, but that they still have a long way to go. The specific questions posed were these:

1. Does the tendency to deny hospital privileges to general practitioners seem to be lessening?

2. What further measures could—and should—G.P.s and hospitals take to encourage the granting of privileges?

The physicians queried practice in the East, South, Middle West, and Southwest. Each tended, of course, to reflect the situation in his own area. Yet what the group as a whole said suggests that conditions are much the same everywhere.

Commission members agree that the G.P. is still low man on the hospital totem pole. As one of them puts it:

"Many institutions stubbornly refuse to accept the principle—approved by the A.M.A. and the Joint Commission on Accreditation of Hospitals—that privileges should be based on ability and training, not on certification."

Hard Knocks for Youth

Dr. John O. Boyd Jr. of Roanoke, Va., says young G.P.s especially are up against it in his area: They're barred from surgical privileges and, as a rule, from obstetrical privileges too. Even their pediatric and medical services are restricted in some hospitals, he adds.

Dr. Boyd tells of an associate who applied for hospital privileges in child care and normal obstetrics. The answer he got: "Our interpretation of general medicine does not include such specialties as pediatrics, obstetrics, or any of their subspecialties."

Another commission member cites this case: A hospital in his state gave a year's training in anesthesiology to a young G.P. Then it offered him anesthesia privileges only if he'd give up his medical privileges and apply for surgical privileges instead.

Just 'Tolerated'

Even where the experienced G.P. isn't excluded completely, hospital doors may be opened only a crack, the commission charges. One of the doctors says, "We're *tolerated* in pediatrics and obstetrics; but we're still made to feel unwelcome." This attitude shows up, he explains, in "many minor slights and mannerisms"—hard to put one's finger on, but none the less demoralizing.

Another member adds: "The family doctor is frozen out. So what does he do? Too often he decides he'd better specialize. He's made to feel that only by moving into a specialty can he ever treat his patients adequately."

In some hospitals where G.P.s are accepted "on paper," they say they're hog-tied in practice. Two examples:

¶ G.P.s at one East Coast institution are allowed to make cardiograms; but they're *not* allowed to interpret them—even for their own patients.

¶ A G.P. who's been given "privileges" at a Southern hospital isn't allowed to admit a child for an appendectomy. First he has to refer the case to a pediatrician, who alone is empowered to request a consultation with a surgeon.

"A number of our hospitals give lip service to a department of general practice—and nothing more," charges Dr. Marshall O. Hart of Tulsa, Okla. "They either violate their own rules (that are supposed to favor the G.P.) or they 'legislate' him out of the picture by piling up requirements he just can't meet."

Dr. Hart tells, for instance, of an Oklahoma hospital that excludes men from staff privileges unless they've had more than a year of interneship—regardless of how much

post-graduate work they've taken. "That eliminates rather neatly most of the local G.P.s," he comments wryly.

Dr. Boyd makes a similar point: In the last few years, he says, his local hospital has voted one change after another in its constitution and by-laws, to limit general practitioners. As a result, since 1950, he has been forbidden to perform the same major surgery and obstetrics that he used to do—"regularly and successfully"—without assistance.

"It's virtually impossible for me to enter a gynecological case conscientiously," he says, "without assuming the role of assistant to some board-qualified diplomate. Yet the procedure may be one that I've done far more often than the diplomate has!"

In spite of such experiences, the commission members are generally optimistic. Speaking for himself—but reflecting the opinion of most of his colleagues—Dr. Charles C. Cooper of St. Paul, Minn., says, "The tide may still be running out; but it shows strong signs of turning." He sees "a liberal situation favoring the G.P." in his part of the country; and he contrasts it favorably with "the deluge of restrictions just after World War II." In similar vein, Dr. A. S. Haines of Mt. Lebanon, Pa.,



"At least we got the traffic problem licked, Billingsley. You have to admit that."

notes hopefully that "specialists in this area are cooperating much more willingly now than they did only two years ago."

What, then, of tomorrow? Will the G.P.'s hospital status continue to improve at "a sort of elderly snail's pace," as one man put it? Or will the family doctor recapture his old position in the hospital more quickly?

'We've Got to Fight'

Dr. Boyd, for one, foresees swift progress. But he warns that "we're going to have to keep fighting—and fighting hard." For a long time, he says, "we kept our gloves on and were careful not to offend hospital boards and specialists. Now it's time to take off our gloves and stop pulling our punches."

Dr. Hart, too, is in a fighting mood. He says: "We have a few friends in the specialties. We have a few friends on the governing boards. But we have an army of enemies in both places." He urges general practitioners in every hospital to muster their forces and to claim their rights militantly.

Other G.P.s insist that the best way to make haste is through moderation—through willing cooperation with specialists. Dr. Cooper, for example, sees things headed in the right direction already. He thinks belligerence now might harm the cause rather than help it.

"Hospitals here in Minnesota," he says, "are making a real effort to integrate G.P.s into their staff organizations. And the G.P.s are accepting increasingly responsible positions. That's the way to move forward."

Dr. Haines sounds the same note: "It's more and more teamwork we want, not more and more friction." Three other members of the commission declare that the G.P. must learn to value himself more highly if he wants others to do so.

"Before we start *demanding* privileges," says one, "let's do two things: (1) Let's start participating more actively in organized medicine and in community activities. And (2) let's become more intelligently critical of the quality of medicine we practice, so that no G.P. need feel apologetic or inferior."

Aims Summarized

On what eventual ends is the A.A.G.P. Hospital Commission setting its sights? Judging from the comments of the members queried, there are five major targets:

1. Establishment of general practice departments in *all* large hospitals. (Some 2,480 institutions now have such departments—at least on paper.)

2. Universal recognition of *ability* rather than of certification as the criterion for hospital privileges.

3. Acceptance of the G. P. in as many departments of the hospital as he's qualified for.

4. Education of the general public in the need for in-hospital G.P. services.

5. Expansion of preceptorship

and school-clinic programs that encourage young men to enter general practice.

Probably not until those aims are achieved will most general practitioners feel that their gains in recent years have been consolidated.

END

His Father Warned Him



● Doesn't this man believe in safety first? He should; he *is* Safety First—Dr. Safety First of Tulsa, Okla. Actually, he's so true to the name that the photographer had to set up an ambush to catch him in this off-beat pose. Dr. First explains he was given his unusual Christian name by his slogan-minded father. His mother, more conservative, injected a middle name—Reuel—during his childhood; so he generally avoids confusion by using the initial. If the "R" isn't sounded when he's introduced, he says, he has a hard time convincing people he's really Safety First. When he succeeds—and they learn that he's a heart specialist, too—some wisecrack invariably follows. (What's yours?)

Ways to House Records More Efficiently

Open-shelf files for case-history folders take less than one third the floor space of cabinet files. Open-tub files for financial-record cards are 30 per cent quicker to use than cabinet files

By Horace Cotton

• Office floor space costs money. Secretarial time costs money, too. And both are on the escalator marked "Up." Yet a pack of chewing gum still costs only a nickel.

The connection? Just this:

Business has proved that higher costs (coupled with a fixed selling price) need not depress profits. Profits may even rise. The key to success here, as Mr. Wrigley and others have learned, is *more efficient operation.*

Take the case of a doctor whose office lacks space and whose aide lacks time for his growing files. Is the expense of additional floor area and extra secretarial help unavoidable? Maybe not. Maybe he could do more with what he already has.

Two efficient filing methods he can use are described in this article. Both can be installed in the same office. I refer to open-shelf filing of folders and open-tub filing of cards. Let's look at the pros and cons of each.

I'll cite first the case of a general practitioner who switched in January to open-shelf filing at my sugges-

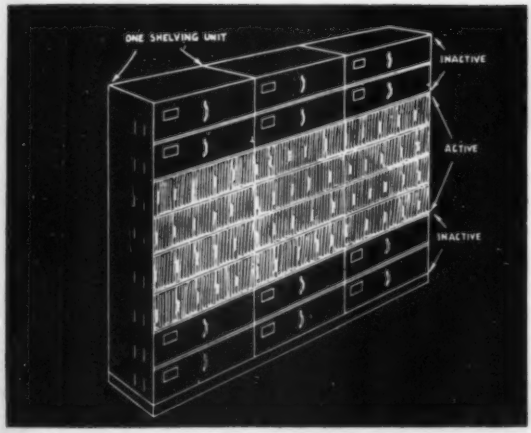
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MR. COTTON *is director of Professional Management, Charlotte, N.C.*

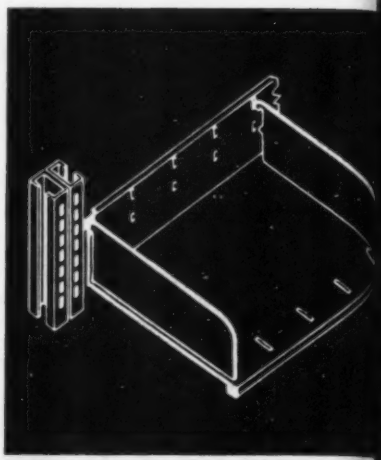


OPEN SHELVES of this steel unit [▶] hold as many folders (3,500) as five four-drawer cabinets do.

CLOSED SHELVES can be used, if desired, for inactive records, as in the top and bottom tiers of this carpenter-made wood unit [▼]. It's constructed in three sections for flexibility of placement.



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METAL DIVIDERS [➤] hold the folders upright. Slots, in turn, hold the dividers upright—and allow them to be moved as needed.

CARDBOARD GUIDES like this [▼], that hook onto the backs of the shelves, let your aide quickly find any folder she wants.



tion. This man has about 3,500 active and inactive patients, for each of whom he keeps a folder containing case history, laboratory reports, correspondence, etc.

Space He Saved

Before this year, he housed these folders in five four-drawer filing cabinets. The cabinets took up 17½ square feet of floor space; and an additional 15 square feet had to be allowed for pulling out the drawers (*not* including standing room for the girl using them). Total: 32½ square feet of floor space for the equipment alone.

Today, on open shelves, this doctor's files take up less than 6 square feet of floor space; and he's been able to relegate them to a small room with a secretary's desk in it, where bulkier cabinets would have been out of the question.

This has had the effect of freeing another whole room for examinations and treatments. So the real gain in floor space is even greater than the figures indicate.

Nor is space saving the only virtue of open-shelf filing. It saves time, too; and it costs less.

What Takes Time

The things that take time when using ordinary file cabinets are the pulling and pushing of drawers, the stretching and struggling to reach folders in the rear recesses of drawers, and the squatting down to get at the contents of bottom drawers. Actually, cabinet files use up a lot more time than is generally realized; and they're a cumbersome nuisance to any office girl who's had experience with open-shelf files.

Had the G.P. I've mentioned bought open shelving at the start, it would have cost him (with dividers) about $115. As it was, the five four-drawer cabinets cost $435. You can generally figure on spending about one-quarter as much for open shelving as for cabinets with equivalent storage space.

"But what are the drawbacks to open-shelf filing?" you may ask. "There must be *some*."

There are. But they're often of minor importance. For instance:

Dust Factor

Dust will collect to some extent on the tops of the folders. But properly planned shelving leaves only minimal space above the folders, so the amount of dust that does get in is small. It can be removed by your cleaning woman with a vacuum cleaner—the way it's done in libraries.

I do *not* recommend open shelves in an office where the files have to be located in full view of patients. Neat though they may be, there's a "nakedness" and seeming lack of privacy about them that's more appropriate in an "inside" room than in a public area like the reception room. Usually, of course, they *can* be placed in such an inside room (or "roomette" or corridor or alcove); in

such an event, there's no problem.

Several-tiered shelving units to which other units can be added are the most practical kind for most doctors' offices. The place to keep inactive files is, of course, in the top and bottom sections. Whether or not you enclose these rarely used sections (see page 103) is a matter of personal choice. The main thing is to keep your active files at thigh-to-eye level on the middle shelves.

A cabinetmaker can build wooden shelves for you. But steel shelving is likely to be stronger and better suited to the purpose. Such shelving comes equipped with rigid dividers that hold the folders vertical yet can be repositioned as needed. There are various devices for affixing the dividers to the shelves at appropriate intervals (say, every 6 inches).

Besides steel dividers to hold the folders upright, you need guide cards to identify them. These guide cards are made of heavy cardboard. They hook onto the backs of the shelves so they won't slip out when folders are removed. The cards are alphabetically tabbed, of course, with each letter subdivided as necessary.

Use Breakdowns Aplenty

To a physician with three or four thousand folders to file, I usually suggest a standard, 200-part set of alphabetical guide cards (with such breakdowns as B, Bak, Bar, Bas, Be, etc.). Other standard sets are available for smaller—or larger—numbers of records. You'll want the one that makes it easiest for your secretary to find the right folder in the least time. (Warning: *Do* use guide cards with plenty of breakdowns. *Don't* use just A, B, C, for instance. The extra cost of the breakdown guides is negligible compared with the cost of otherwise lost secretarial time.)

After spotting the correct tab, your aide need merely scan a dozen or so names—typed on labels on the top outside corners of folders—to find the correct record. (It's a good idea to attach a name label to the lower outside corner, too, if the folder is to be filed among the inactive records on the top shelf.) Getting a folder off the shelf is made easy by the fact that the folders (and guides) are fashioned so as to overhang the 10-inch-deep shelf by 2 inches.

Open-Tub Filing

For the doctor who keeps patients' records on cards, I often recommend open tubs (rather than shelves) to replace the traditional push-pull drawers. Here, it's less a matter of space-saving than of time-saving and general efficiency.

In a tub file (see cut), all cards are kept on one level and within easy reach of the aide. Besides, the tub can be on casters for wheeling wherever it's convenient for the girl to work with it.

Some tub files are designed for use in a standing position; some, in a sitting position. A useful append-

age is a writing platform that slides, left or right, above the cards, as illustrated.

Tub filing is a relatively new idea; and most of the equipment made so far has been designed for large businesses. However, a cabinetmaker can readily build a tub file to your specifications.

One of my doctor-clients has one that measures 42 inches wide, 19 inches deep, and 43 inches tall (standing height). The built-up walls are 6 inches high. There are three 4-inch-high partitions. And the tub holds four trays of 5″ x 8″ cards. Its capacity: some 3,200 double cards.

Starting from scratch with open-shelf and open-tub files is simpler, of course, than switching to them once you've set up cabinet files. Yet doctor after doctor has told me that he hasn't begrudged for a moment the effort needed to effect a change-over. Says one:

"I now have more elbow room and more over-all office efficiency than I ever had before. Six months ago, I wouldn't have thought it possible for such a slight change to make such a big difference." END



OPEN TUB file has a prime advantage: The cards inside are always immediately accessible. Reasons for this accessibility: There are no drawers to open, the cards are handled at waist level, and the file can be fitted with casters. Result: A big saving of time. The open tub shown is one of several commercial models on the market, all of which are too big for the usual medical office. A file about half this size, built by a local cabinetmaker, would serve the average solo physician nicely.

'Master Surgeon'– And True-Story-Teller

This famous doctor's autobiography makes it clear that, as he shuttled among the gamy courts of Europe, he knew how to operate

By Helen C. Milius

● Do you sometimes tire of the daily routine of office hours, house calls, hospital rounds? Do you wish your practice were a mite more glamorous? Do you crave the excitement that might come from having, say, dukes, duchesses, dictators, and do-nothings as your patients?

If so, you'll enjoy reading about a modern physician who spent a good share of his professional life in the flamboyant world of international intrigue. His name: Ferdinand Sauerbruch.

The late Dr. Sauerbruch was the German-born surgeon who made thoracic surgery possible—only fifty years ago—by inventing a differential pressure chamber that prevented pneumothorax. Thus catapulted into fame, he soon found the princes crowding the paupers out of his practice.

Presidents, kings, statesmen, generals, tycoons, petty nobility, and their pampered womenfolk began streaming to him from several continents. Wherever he moved—from Zurich to Munich to Berlin—such patients followed him. And they gave him plenty of trouble as well as excitement, according to his autobiography, which—after

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having long been on best-seller lists abroad—has now been published in this country.*

"I have often been asked what it was like to operate on a king or a dictator or a multimillionaire," writes the author, who died in 1951. "I dislike the question . . . If the reader believes that a surgeon operates more carefully on a rich patient, he is mistaken. The surgeon automatically gives his best. He is, if anything, at a disadvantage when operating on the great, for just as success will add to his reputation, failure may destroy it."

Another apparent hazard of a Sauerbruch-type prac-

*"Master Surgeon," by Ferdinand Sauerbruch. Translated from the German by Fernand G. Renier and Anne Cliff. Thomas Y. Crowell Company, New York, 1954. 277 pages. $3.50.

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tice: assassins. The autobiographer says he first learned this fact in 1917 —from King Constantine of Greece. The story, as he tells it:

When the King checked in at the surgeon's Zurich clinic, the Swiss security police moved in, too. "One attempt had already been made on the King's life in Switzerland," the surgeon recalls. So the police were "unpleasant but necessary . . . Night and day, in shifts, they guarded our doors, screening every patient."

In spite of strict policing, the assassin scare gave the doctor "a night of fear and terror." In the middle of one night, he and the entire clinic were aroused by strange noises in the basement. With only one exception, he writes, everyone was "convinced that a murderer was on the premises. The one person who had to be wakened from a sound sleep was the King's bodyguard."

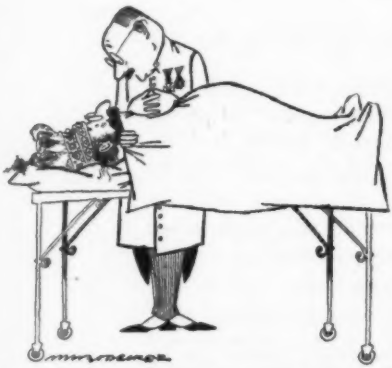
The noises were finally traced to an unexpected source: a chicken penned under an inverted copper kettle, awaiting slaughter in the morning.

And what about the royal fee? Did King Constantine pay it resplendently in crown jewels? He did not. "The King informed me that he did not possess a cent," the surgeon admits in his book. "It was a serious matter to me, as he was still holding court in my clinic, and the expense for drinks alone was considerable... *Noblesse oblige:* I assured him that he need not worry."

So Sauerbruch went gracefully into debt for his distinguished patient's sake. He even risked his neck for the exiled ruler of Greece:

> As one move in his campaign to save his crown, Constantine induced the doctor to smuggle a letter to the German Kaiser. This seems to have involved Sauerbruch in a secret cloak-and-dagger mission across wartime Europe; he had to carry messages from the Kaiser to the King of Bulgaria and the Sultan of Turkey. (As a reward, he says, he collected two jeweled orders of knighthood.)

Eventually, Constantine regained his throne—at which time, Sauerbruch says, "he immediately thought of me and paid his Zurich account, which



"... the King informed me that he did not possess a cent."



"... the portrait should stay in the family."

enabled me to pay off my remaining liabilities in Switzerland. He also bestowed on me the highest Greek distinction, the Order of the Redeemer, which conferred on me the right to the title 'Excellency,' and for a while people in the clinic used it, but, thank God, they soon forgot."

Pampers Hindenburg

The doddering German President Hindenburg was another high-placed figure whose failure to pay got the doctor into a jam. The 87-year-old Hindenburg was an appreciative patient back in the early Thirties; and Sauerbruch made rather a pet of him, according to the autobiography.

But the old man continually pleaded poverty. He even lamented the expense of having a suit cleaned. So the doctor sent him no bills. Instead, he planned to content himself with an oil portrait that Hindenburg impulsively offered him. When the President died, however, a daughter-in-law protested that the portrait should stay in the family; so the doctor didn't get it.

But Hitler insisted on clearing up any government liability for the late President's medical care. When Sauerbruch refused to send a bill, he says, the Nazis settled the account by giving him the empty title of State Councilor and a monthly stipend of $175.

He accepted the title—but, by his own account, turned the money over to charity. None the less, years later, he was brought to trial before denazification officials because of this deal with the Nazis. [MORE ▶

Whether he collects in kudos or cash—indeed, whether or not he collects at all—the medical adviser to the mighty evidently finds the eyes of the tax men always upon him. For example:

When King George V of England showed symptoms that indicated thoracic surgery, Sauerbruch was consulted. Royal advisers feared it would be impolitic for a German surgeon to perform the operation. So he was asked merely to give an opinion on the basis of X-rays.

"The part that I played, therefore," he relates, "was to write a few sentences giving an outline of the course I myself would have followed . . . Someone from the British Embassy called on me to receive my answer. I handed him the documents and for the time being that was the last I heard of it."

But repercussions began within a week and hounded him recurrently almost until his death many years later. For instance, he was induced to fly to England to the bedside of a cousin of the King. The trip inspired a rumor that Sauerbruch had operated on His Majesty—and had collected a fee of a million gold marks. American and German newspapers blared out the rumor as a fact.

'Where's the Money?'

"I never bothered to publish a denial," he confesses ruefully. "Nobody would have believed it. But if *I* took no action, the income-tax authorities did . . . I was summoned to an interview: 'You have not declared the fee paid you by the King of England' . . .

"It was exceedingly difficult to convince them of the truth . . . I could only reiterate that (a) I had not operated on the King and (b) I had therefore not received a fee. I made this statement in the form of a signed declaration, but it was clear that I was considered a brazen liar who would soon be found out."

More than a decade later, the mirage of the mythical fee was still shimmering. At his denazification investigation, the question rose again: " 'And where . . . have you hidden the million marks paid you by the King of England for his operation?' "

Can a medical man avoid politics when high-voltage political figures are under his care? "I have never known much about politics and have never regretted my ignorance," Sauerbruch asserts. Yet he claims that his life was sometimes endangered by his *patients'* political activities.

He insists, for example, that he stood in the shadow of the noose when, in 1944, Hitler was nearly assassinated. According to his story, the conspirators used his home for a meeting place and even included him in one of their gatherings, to give it a nonpolitical appearance.

After the plot failed, he claims to have been hauled up for questioning; and one of his sons was arrested.

What rescued the family was the intervention of one of the doctor's former medical students, who vouched for Sauerbruch's innocence in a plea to Hitler himself.

Once before, Sauerbruch's "ignorance" had failed to insulate him when a patient brought politics crackling into his clinic. During Germany's 1918 revolution, he writes, he hospitalized Count Anton Arco-Valley for a near-fatal bullet wound. The Count turned out to be the assassin of a revolutionary leader; but Sauerbruch refused to turn him over to the authorities for punishment.

For this, it seems, he was himself condemned to death. But he escaped —just fifteen minutes before he was to have faced a firing squad.

Dr. Sauerbruch's life, as he recounts it, appears to have been a constant series of such incidents—most of them, curiously enough, equally inconclusive. The skeptical reader may become even more skeptical as he reads; but, at the very least, he's bound to be entertained.

Take what happened in 1940 as an example: One day, the surgeon was carried by car and plane to a secret underground headquarters in the Ukraine and delivered like a parcel to Adolf Hitler. [MORE ▶



". . . delivered like a parcel to Adolf Hitler."

"You must cure the Turkish Minister," was Hitler's order. It developed that the Turkish Minister of Foreign Affairs, a former patient, needed thoracic surgery again—and Hitler needed Turkey. So the doctor was shipped to Ankara in Hitler's private plane; and he was kept in Turkey till he succeeded in saving the Foreign Minister with two more operations.

When a doctor treats such policy-shaping patients, the notion arises that he may well have a hand in shaping history. Sauerbruch tells of operating on General Ludendorff for exophthalmic goiter, in order to relieve distress the general had suffered since the early months of World War I.

"If you had done this operation many years ago," he claims Ludendorff told him, "we should have won the war."

How He Set Fees

How does a doctor set fees for patients whose economic status is dazzlingly exceptional? Dr. Sauerbruch first faced that problem in 1910, when he successfully treated the richest man in Switzerland for varicosities in the legs.

What about a bill?

The surgeon didn't send one. He waited till the patient, a notorious penny-pincher, demanded, "How much?" Then he parried with: "How much are healthy legs worth to you?" The old man thereupon counted out 5,000 Swiss francs—in 1910, about $900—and threw in the advice that the doctor was living beyond his means.

A year later, he encountered the patient on the street. And the old fellow stuffed an additional 2,000 francs into the physician's pocket before they separated.

'Not Even Galen'

"Everybody, except the surgeon himself, is convinced that surgeons receive fantastically high fees," Sauerbruch says. "Not even Galen in ancient Rome, who was probably the best paid surgeon ever known, could have received the sums popular opinion puts in our pockets."

He admits having performed an operation once for 50 pfenning, the equivalent of 12 cents. The patient was the wine steward at his favorite Berlin restaurant; and Sauerbruch operated, he says, mainly to keep his meals from being spoiled by a recital of the man's ailments. Then, when the steward pestered him for a statement (repeatedly saying, "I'm worried about it, for I know how high your fees are"), the proffered bill for 12 cents enabled Sauerbruch to enjoy the cuisine again.

Dogs and Heirlooms

In some cases Sauerbruch collected in a form other than currency. A grateful British Duke offered him a pack of hounds. The painter Max Liebermann gave him a portrait sketch showing the surgeon's expression during an emergency. A Scot-

tish nobleman sent him a replica of an historic heirloom the family had received from an English monarch—a silver bowl which was inscribed with the words, "With Profound Gratitude."

Once, Sauerbruch happily got more than he'd bargained for: He considered himself well enough paid with an order of knighthood from the Sultan of Turkey, when he was asked to examine a closely guarded harem favorite. He found that she was a German girl he had known in childhood, who was suffering from nothing but a desire to escape. They agreed on a ruse: She would fake the symptoms of a lung abscess; and he would report that she needed an operation performed only in Europe. It worked.

House Not a Home

Years later, in Leipzig, he was invited to sup with the escaped favorite in her own establishment. When he reached the address, he recalls, "I was taken straight to the madame, and was looked after very well indeed, though not in a way of which Plato would have approved."

Errol Flynn in the latest Hollywood extravaganza couldn't have asked for more. END

Big Deal

● The patient, a young buck of 24, resplendent in a checked suit, arrived at the hospital O.P.D. with a perforated peptic ulcer, confirmed shortly afterward by an X-ray finding of pneumoperitonitis.

When I told him he'd have to be operated on without delay, he agreed to "play a long shot" but said he'd "have to talk to Joe Beback first."

He didn't have the man's phone number; and time was at a premium; so one of the nurses made a frantic search for a Joe Beback in the phone book—without success.

Still the patient insisted on speaking to Beback before being operated on. So, with ill-concealed impatience, I said, "Look—who *is* this Beback, that you've got to hold up a major operation so you can speak to him first? Is he a close relative, a clergyman, a lawyer—or what?"

"No, No! Nothing like *that*," he replied. "He's my *bookie!*"

—CHARLES J. SHAGOURY, M.D.

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The Doctor's Widow Gets a Break

These physicians have set up a plan to help their colleagues' wives dispose of medical practices and equipment at fair prices

By Thomas Owens

● Last May, a smooth-talking dealer in medical equipment persuaded a Los Angeles doctor's widow to sell an almost new proctologic table for $50. "Used equipment has practically no resale value," he told her.

Two days later, he netted a cool 600 per cent profit by selling the $750 table for $350.

There's nothing new about this story. Over the years, widows (in California and elsewhere) have undoubtedly been cheated out of thousands of dollars in such sharp transactions. What *is* new is this:

No more such cases are likely to occur in Los Angeles County. Reason: Special welfare committees of local doctors now make all arrangements for selling both the equipment and the practices of their deceased colleagues.

The man who spark-plugged this service to medical families is Dr. Arthur A. Kirchner, a director of the Los Angeles County Medical Association. It was the proctologic table fraud that got him started on the project. After seeing the widow's advertisement in the county medical bulletin, he had phoned to ask about the table. But she had already sold it to the dealer; and he, in turn, had disposed of it.

Ordinarily, Dr. Kirchner, a gastroenterologist, would have accepted his bad luck philosophically. But, by chance he learned that the dealer had made a fast $300 profit at the widow's expense. As chairman of the county society's medical economics committee, he'd heard of similar unsavory deals; this one capped the climax.

So he went into action. First, he held a conference with representatives of several reputable surgical supply houses. They suggested a simple plan, involving two steps:

1. In the future, when a Los Angeles physician died, one of the ten participating houses would appraise the doctor's equipment free of charge.

2. Dr. Kirchner (with the help of a committee to be set up by the medical society) would try to find a doctor to take the equipment at the agreed-on price. If none could be found, the supply house would buy it.

As far as it went, the scheme was a good one. It meant, at least, that the widow would be sure to get a fair price for medical equipment. But Dr. Kirchner soon realized that the average woman needed help also with a much harder problem: selling her husband's practice.

So he decided that the projected committee of M.D.s should be set up to handle all details of selling *both* equipment and practice. He discussed the matter with other doctors before attempting to make it official; and they agreed with him. Often, they felt, it might be possible to sell everything in a package deal to a young doctor just starting out.

Dr. Kirchner had a chance to test his plan even before the new committee was organized. When a Hollywood woman, whose husband—a G.P.—had died unexpectedly, called the medical society for assistance, her call was transferred routinely to the chairman of the medical economics committee. [MORE ▶

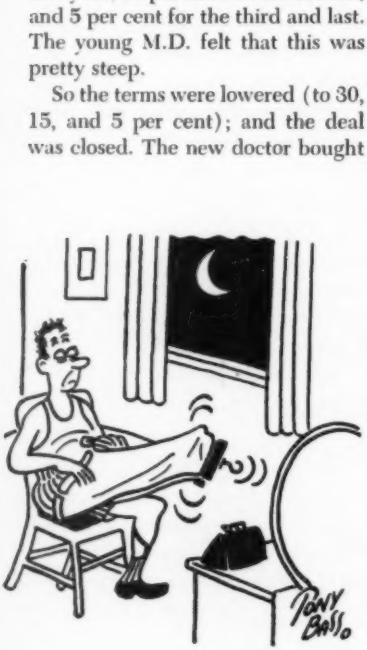
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In this capacity, the doctor told her about his project; and, of course, she was more than willing to put in his hands the disposal of her husband's medical assets. So Dr. Kirchner arranged for an appraisal. Then, with the unofficial help of a couple of colleagues, he located a young doctor interested in buying a general practice.

The prospective buyer balked at the proposed terms, however. These provided that the widow would get 40 per cent of the gross from her husband's patients of record for the first year, 20 per cent for the second, and 5 per cent for the third and last. The young M.D. felt that this was pretty steep.

So the terms were lowered (to 30, 15, and 5 per cent); and the deal was closed. The new doctor bought the equipment at the price set, rented the deceased doctor's home-office, and began building a very satisfactory practice.

Now, less than a year later, things are apparently working out fine for both parties. Unlike his predecessor, the new doctor is doing OB work, pediatrics, and minor surgery. He's happy with the resultant increase in patient-load. And the widow is more than pleased at the income she gets under the percentage arrangement.



Widows Notified

"We were tremendously encouraged by our success with our first effort to help a colleague's wife," says Dr. Kirchner. "So—still unofficially—the medical economics committee began the practice of sending a form letter to each new widow, whenever we learned of a doctor's death. In the letter we explained what we were prepared to do and offered our services."

After a few months (and a number of satisfactory transactions), it was felt that the plan had passed the experimental stage. Dr. Kirchner then recommended that it be made an official part of the county society's program; and his fellow directors agreed.

A welfare committee has now been set up in each of the fifteen branches of the county association. And Dr. Kirchner himself, not surprisingly, heads the committee in the metropolitan branch.

With the program well under

way, Los Angeles doctors are justifiably proud of its accomplishments. The only major difficulty so far: locating buyers for available practices. "But at the present time we're solving at least part of that problem without much trouble," says Dr. Kirchner.

The Supply Is Good

They're finding prospective buyers through several sources, he points out. For instance:

1. The welfare committees are given free space in the classified advertising section of the county medical bulletin.

2. As the result of a recent questionnaire sent out by the medical economics committee, they have a list of the placement needs of all internes and residents in Los Angeles County.

3. They get the full cooperation of the placement bureaus of two medical schools in the area.

It Works Both Ways

What began as a service to widows is already becoming an equal boon to fledgling physicians. If, for example, a promising young M.D. who wants to buy a practice lacks the ready cash, Dr. Kirchner and his colleagues are prepared to help out.

"On a committee recommendation," says the doctor, "our board of trustees will cosign a buyer's note (for up to $1,500) at any local bank. Also, we keep in constant touch with foundations and private individuals willing to help young men get started. So we seldom find financing a sale to be a real stumbling block."

'Don't Wait for Death'

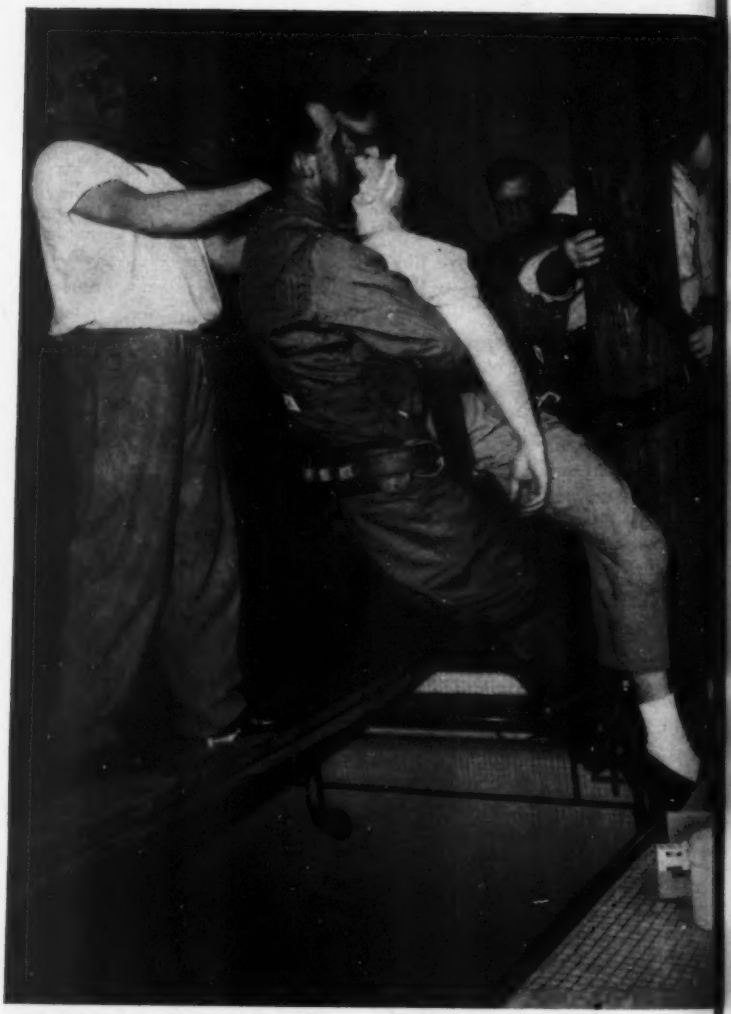
There *is* one hard nut that the doctors haven't yet managed to crack: They've found that specialty practices are extremely difficult to sell. Obviously, the estimated value of such a practice may prove unrealistic if referrals don't meet expectations; and most young practitioners, well aware of this fact, hesitate to take the gamble.

"I become more and more convinced that the specialist should prepare to transfer his practice while he's still alive," says Dr. Kirchner. "For the good of his family, he ought never to forget that a specialist's practice is likely to die when the specialist dies."

The Los Angeles physicians' medical economics committee is now making a study of the best ways in which to transfer a live practice. On the basis of what they've learned so far, Dr. Kirchner has this bit of advice for specialists everywhere: "Take on a junior partner—for your family's sake as much as for yours."

As the originator of the Los Angeles welfare plan, what does he think of its chances for success in other areas? "No reason why programs like ours couldn't work in every part of the country," he says. "All that's needed, seems to me, is the initiative to start them going." END

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They Risked Their Lives For Medicine

The Walter Reed Society spurs research by formally recognizing 'the contributions to medical progress of the human medical volunteer'

By Peter Jaeger

• Medical student Lloyd T. Koritz decided in 1950 that "before a doctor hands out medicine, he ought to sample some himself." So he offered to let one of his professors at the University of Illinois College of Medicine use him as a subject for experiments in artificial respiration.

During each of those experiments, young Koritz was deeply anesthetized, then given an injection of curare. With an endotracheal tube inserted, most of his body's voluntary functions were suspended. A recording sphygmomanometer and an electrocardiograph kept tabs on his cardiovascular action.

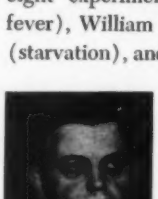
While he lay in a complete state of paralysis, like that of a shock or drowning victim, all the conventional methods of artificial respiration were tried on him. A slip-up at any moment could have meant his death.

But he didn't die. Instead, he recovered fully and went

HUMAN GUINEA PIGS, like this volunteer for resuscitation experiments, deserved recognition, Dr. Max Sadove (left) believed. So he helped found the Walter Reed Society.

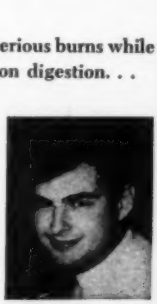
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The Walter Reed Society has so far granted special citations to eight experimental volunteers: Gustus E. Lambert (yellow fever), William H. Hacker ("trench mouth"), Anton J. Carlson (starvation), and these five M.D.s:



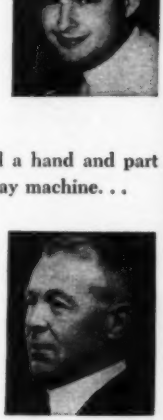
◀ **Andrew C. Ivy, who suffered serious burns while participating in experiments on digestion. . .**

Lloyd T. Koritz, who gambled his life in a series of artificial respiration experiments. . . ▶



◀ **Emil Grubbe, who destroyed a hand and part of a lip in developing the X-ray machine. . .**

William G. Clark, who hurt an eye in experiments on "G" forces (acceleration pressure). . . ▶



◀ **Arno B. Luckhardt, who took part in 800 experiments on the road to discovery of ethylene anesthesia, risking blowing himself up.**

on to become a physician. Today, he "hands out medicine" as a G.P. in Rochelle, Ill.

Today, too, as a result of his volunteer work, others who might have died may also be alive. For the experiments described were the basis of the now widely accepted Holger Nielsen method of artificial respiration, adopted by the U.S. armed forces, among others, in preference to the Schaefer method.

The professor to whom Lloyd Koritz entrusted his life was Dr. Max Sadove, who heads the college's department of anesthesiology. It occurred to Dr. Sadove that there ought to be some formal recognition, by a society, of the scientific contributions made by such willing human guinea pigs.

So he broached the subject to Dr. Andrew C. Ivy, who was at that time a vice president of the Illinois institution. Dr. Ivy, who had himself played the role of a medical volunteer, liked the idea.

Society's Aims

In December, 1951, sparked by the two Illinois physicians, the Walter Reed Society was formally organized. Named, appropriately, to recall the volunteers who helped Dr. Reed discover the cause of yellow fever half a century ago, the society has four objectives:

1. "To provide recognition for contributions to medical progress by the human medical volunteer."

2. "To provide for the exchange of scientific information on medical experimentation involving human subjects, so that clinical research may become increasingly efficient and safe."

3. "To afford medical research volunteers . . . a continuing role in the war against disease."

4. "To develop public understanding and support of medical research."

Who Belongs

The organization now has 165 members in thirteen states and the District of Columbia. Some of these are M.D.s; others are not. Membership is by invitation only; and names are chosen from lists submitted by established scientists and institutions. Sole qualification for membership: The nominee must have voluntarily participated *as a subject* in medical or scientific experimentation.

So it is that every member of the society has pushed medical research a step or two forward. Eight of them have been awarded the organization's special citations. But even those who haven't won citations have taken real risks for the sake of science. Examples of the latter are three doctor-members: William R. Lovelace II, the late Sidney O. Levinson, and Dudley Jackson.

In 1943, as chief of the Aero Medical Laboratories at Wright Field, Dr. Lovelace was faced with this puzzler: What happens to the body of a man when he bails out of a mod-

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ern, high-speed, high-altitude aircraft? To find out, he buttoned himself into a special flying suit equipped to measure temperature, blood pressure, muscle tension, and other reactions.

Then the man who only a short time before had been an earth-bound surgeon at the Mayo Clinic settled himself in the bomb bay of a plane. It climbed 40,000 feet—and dropped him, with a slow-opening parachute.

On the ground, after having plummeted most of the 40,000 feet in a free fall, he acknowledged that he'd been scared to death. But he'd found out what he wanted to know.

Today, his parachuting exploits behind him, he directs the Lovelace Foundation for Medical Education and Research in Albuquerque, N.M. He also heads a section on surgery at the Lovelace Clinic.

Of Mice and Men

Fear shadowed Sidney Levinson's adventure, too. Back in the early Forties, as an assistant professor at the University of Illinois College of Medicine, Dr. Levinson (who died only a few months ago) directed a research project undertaken jointly by the college and the Michael Reese Foundation. As a result of this research a vaccine was developed to combat bacillary dysentery.

Trouble was, the vaccine turned out to be so toxic that inoculated mice sometimes died within a few minutes. So human reaction to the vaccine, still unknown, had to be determined. The outcome of this further research would be of top importance for two reasons: Bacillary dysentery had long been a scourge of the tropics. It was now even more so because it threatened to undermine U.S. military strength in the Philippines.

In 1945, Dr. Levinson and Dr. (of philosophy) Howard J. Shaughnessy volunteered for the critical test. They knew what could happen: The toxin could attack the nervous system—in which case there'd be a sharp drop in blood pressure, followed by a period of shock and, possibly, death. Or it might find its way to the digestive tract, with resultant spasms of the gut and high fever.

They readied emergency equipment to handle either eventuality, then got down to business. Assistants stood by to administer hypodermics of epinephrine and sulfadiazine, if needed, as the two men were inoculated with the serum.

Minutes passed, and tension mounted. Their arms began to swell painfully and their temperatures rose. But after a couple of hours of heavy sweating, microbiologist Shaughnessy ended the suspense:

"I guess if this stuff were going to kill us, we'd be dead by now."

The experiment was over. A new vaccine had been proved safe for human use.

A far longer period of suspense was necessary for Dr. Dudley Jackson: As an acting assistant surgeon

for the Public Health Service in San Antonio, Tex., some years ago, he'd made an intensive study of whether or not cancer could be transferred from sick to healthy animals. "To complete the research," he now says, "I realized I'd have to transplant a cancer from man to man. So, in 1939, I did it."

A small piece of cancerous tissue was removed from a dying patient and transplanted into the subcutaneous tissue of the doctor's own abdomen. The experiment had negative results—as Dr. Jackson had expected it would. But it was an uncomfort-





FOR BAILING OUT eight miles up in this outfit [▲] to test atmosphere's effect, Dr. William R. Lovelace II was decorated with the Distinguished Flying Cross [◀] by General Henry A. Arnold.

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able several weeks before he could be positive he hadn't given himself a malignancy.

"Someone had to try it first," he says today. "There was too much misunderstanding of the disease back then. Too many laymen—40 per cent, according to one survey—blindly believed it was contagious. Somebody *had* to prove them wrong. The job seemed to me to present the same sort of challenge as an unclimbed mountain."

In a way, Dr. Jackson is still climbing medical mountains. Since 1939, he has researched breast cytology for the National Cancer Institute, directed the Nix Tumor Clinic in San Antonio, and taught surgery at Baylor Medical School—besides carrying on a private practice.

The Walter Reed Society operates on a near-zero budget. Its officers are unpaid. Its clerical costs are defrayed by annual dues of $1 per member and by small gifts from the National Society for Medical Research.

"As a matter of fact," says the secretary, Dr. Y. T. Oester of Chicago, "we're even talking about abolishing dues. We feel we could get enough money for our limited purposes in the form of voluntary contributions."

From a group of men who've made a few voluntary contributions of their own, this isn't too surprising an idea. END

Medicine, It's Wonderful!

● It was 1 A.M. The sheriff was on the phone. He had a woman in custody who claimed she had been raped. Could I possibly examine her then?

I said I could. And I told him to meet me at my office in ten minutes.

While the woman was removing her clothes, the sheriff confided that she had been drinking and that he doubted she had been raped at all.

During the examination, to make some small talk, I said, "Apparently, you've been drinking."

Immediately, her disbelieving, questioning reply came back:

"My God, can you tell *that* down there?"

—D. J. HAFT, M.D.

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How to Pick a Health and Accident Policy

An insurance consultant suggests six things to consider before you settle on any given policy

By Spencer M. Schryver

● Dr. Stevens, at 40, had a good savings plan, a sound retirement program, and ample life, fire, liability, and malpractice insurance. But he had no protection against loss of income resulting from a serious accident or illness.

He'd talked with a number of insurance salesmen about it. In the process, he'd become completely confused. Buying *any* kind of insurance took a good deal of careful thought; but health and accident seemed the trickiest of all. How, he wondered, did you choose among the countless contracts, mail-order and otherwise?

He was still wrestling with the problem when a colleague suggested that he consult me. So he made an appointment and came to my office. Here's a capsuled version of the advice I gave him:

1. Choose a reliable company that's licensed in your state. By doing so, you're protected by your own state insurance department.

At first blush, this sounds like obvious advice. Yet many people fail to follow it. They see an ad of a mail-order company in their local newspaper. It sounds like a good deal and they buy. Later, if the company fails to

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MR. SCHRYVER *is an independent insurance consultant.*

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honor a claim, they find out that they have no recourse.*

It's a simple matter to check with your state insurance department. Such a check will at least indicate what companies to avoid.

The Right to Renew

2. Get a noncancelable, guaranteed-renewable contract. The preferred policy is one that's renewable, at the option of the insured, to age 65. This assures you a continuous income during long periods of disability.

Note that most policies are not of this kind. They're cancelable contracts that may be terminated by the insurance company at the end of the premium period if a claim for disability seems likely to recur. Avoid them!

Group health and accident insurance plans approved by medical societies always employ a cancelable contract. So, while they often offer wider protection at cheaper rates than plans available elsewhere, the fact remains that either the company or the group *may* refuse to renew your policy at the end of its term (usually one year).

The Fine Print

3. Watch out for escape clauses. Some policies, for example, require house confinement before benefits will be paid. Under such a clause, a company can refuse to pay claims to a disabled policyholder for such things as blindness, neurasthenia and paralysis agitans.

Other polices require periodic doctor visits (as often as once a week) before claims will be met. Any such escape clause should make you wary of buying.

4. Aim for long-term coverage. Although you can buy accident policies that pay for life, it's a rare company that offers noncancelable health insurance on the same basis. Ten years is about the best coverage that's available for any one sickness.*

What 'Aggregate' Means

5. Beware of any policy with an aggregate clause. This is a limit on the total payments made for all disabilities.

Suppose, for instance, you hold a policy with an aggregate limit of one year. You become disabled for ten months and then recover. If, later, you again become disabled, you'll collect only two months' payments. After that you'll be left with no health and accident protection at all; and, to make things worse, you won't be able to buy any additional coverage.

6. Take as long a waiting period as you can afford. Some policies pay from the first day of disability. Others specify a waiting period of

*Except for claims of $3,000 or more, which can be taken to a Federal court.

*Lifetime disability insurance can be bought from a few companies in conjunction with life insurance, but it's highly expensive. And in most cases, your disability must begin before age 55, or you won't collect.

fifteen days or more before payments begin.

The longer the waiting period, of course, the lower your premium cost. If your savings can tide you over, take a thirty-day waiting period at least.

What to Buy

With the help of those six tips, Dr. Stevens soon had a pretty good idea of what he should get: a noncancelable contract, renewable to age 65, providing lifetime payments for accidental disability. As for disability resulting from illness (since lifetime benefits aren't generally offered by worthy companies), he'd have to settle for the longest coverage available. To keep premium costs down, he'd be willing to take, say, a ninety-day waiting period.

At this point, he raised the jackpot question: "How much insurance do I need?"

"Ideally," I told him, "your insurance should pay you whatever you need to meet your fixed, inescapable domestic and professional expenses. But as a practical matter, it's hard to arrange for benefits that total more than about $700 a month."

The doctor nodded. He figured his monthly overhead at around $1,000, he told me. But he knew he could shave it down to $700 in an emergency.

Now for specific policies:

I recommended that he buy two contracts, issued by separate companies. Both were noncancelable, guaranteed-renewable to age 65. Each would pay a monthly benefit of $350 (the maximum for one company; within $50 of the maximum for the other) from the ninety-first day of disability.

Accident payments would continue for life, if necessary. Sickness benefits would be payable for up to ten years. Total cost of the two contracts (at age 40): about $560 a year.

Dr. Stevens bought the policies I advised. As a result, if he becomes permanently disabled following an accident, he'll get $700 a month for life. If permanently disabled by illness, he'll get $700 a month for ten years—up to age 70.

Policies of the sort described are not the ones most commonly sold. But they are the kind to buy, and they're available in most states to the doctor who shops around for them. END



The Kintner Pension Plan: Its Meaning for You



By A. M. Platt Jr. and Joel Berg

Now that one U.S. medical group has won its legal right to a tax-exempt retirement program, how about other groups? How, too, about the solo man? Here's a complete round-up of fact and opinion on a matter of interest to all M.D.s

• At least some of the nation's private physicians now have the legal right to enjoy Federal-income-tax-favored pension plans. They've had the right since last December, when the Government decided not to ask the Supreme Court to reverse the ruling of a U.S. Court of Appeals in the test case, *Kintner v. U.S.*

The case, you'll recall, concerned the taxation of a retirement fund set up by a group of doctors, headed by Arthur R. Kintner, who operate the Western Montana Clinic, in Missoula, Mont. The effect of the precedent-setting decision was to give the clinic's pension fund the same liberal tax treatment given to pension funds established by corporations for their employes.

Money paid into a corporate retirement fund isn't considered taxable income to the employe until he gets it in his post-retirement, low-income years. What's more, the fund pays no Federal tax on any income it earns from investments. So the Montana doctors, who now enjoy the same tax status, stand to profit considerably from the court ruling.

Before last year, it was assumed that private physicians couldn't set up such an employe retirement fund. The reason: State laws generally forbid doctors to incorporate for the practice of medicine. But the Kintner decision seems to point out a legal way in which certain physicians can (to coin a phrase) eat their cake and have it, too.

Why only "certain" physicians? Because, for one thing, the Kintner decision applies only to doctors who practice in groups. Solo practitioners who'd like similar Federal tax relief on their savings are out of luck—at least until Congress passes a law permitting self-employed individuals to set up their own tax-exempt pension funds. [MORE▶

Then, too, the Kintner ruling holds good so far only in a limited geographical area. Group practitioners who seek similar tax relief in other parts of the country may not find it easy to get.

Nevertheless, the outcome of the Kintner case is a good, long step in the right direction. For a better understanding of the case itself—and of its possible meaning for you—suppose we consider three key questions:

1. How did the Montana doctors manage to get corporation tax benefits without actually incorporating?

2. Exactly what advantages does their tax-exempt pension plan give them?

The Man Behind the Plan



Spark plug of the Western Montana Clinic and star witness in its six-year court battle over doctors' pension rights is Arthur R. Kintner. Dr. Kintner got his training in internal medicine at the Mayo Clinic. "It was there," he says, "that I became sold on the virtues of private group practice. But I wanted to join a relatively small group, where I could assume some responsibility for management and policy." So in 1932 he joined the Western Montana Clinic in Missoula, as one of its six partners.

Today, Dr. Kintner is the senior member of the group. Nineteen board-certified specialists comprise the professional staff.

How well Arthur Kintner has fulfilled his "responsibility for management and policy"—in at least one sphere—is made clear in this article.

3. Can groups in other states set up such a plan—and, if so, how can they do it?

In 1948, the Montana doctors changed their form of organization from a straight partnership to an unincorporated association. In doing so, they maintained, they were entitled to be considered a corporation under Federal tax law, though still a partnership under state law. Their reasoning:

Federal law specifies that an association closely resembling a corporation must be taxed as one. And the Kintner clinic, as the doctors pointed out, was very much like a corporation:

Like a Corporation

The clinic as a legal entity (and not the doctors as individual partners) owned all the assets. It was administered by a "board of directors" elected by and from the doctor-members. And it hired all its medical staff as *employes*.

Under Montana law, though, the clinic was still a partnership because it lacked *actual* incorporation. Also, it retained many partnership features:

In addition to his basic salary, each M.D. continued to get a share of the net earnings of the group. And the physicians retained control of the association. So, though legally employes, they were also in a sense self-employed.

As might have been expected, the Government challenged the clinic's right to be taxed as a corporation. It said: (1) Since Montana law forbade doctors to incorporate, the association *couldn't* be a corporation; therefore, (2) the clinic's doctors were partners, not employes. On these grounds, the U.S. refused to grant tax-exempt status to the association's pension plan for its employes.

Government Loses

On both counts, the Government lost its case. Two courts (the U.S. District Court of Montana and the Ninth Circuit Court of Appeals in San Francisco) upheld Kintner. In so doing, they enunciated a significant legal principle: Even though an association is a *partnership under state law*, it may have special features that make it a *corporation under Federal law*.*

By its victory, the Western Montana Clinic has assured the continuance of its pension plan for the doctors on its staff (as well as for all its other qualified employes). Specifically, here's what this will mean to Dr. Kintner and his medical colleagues:

¶ The physician will pay no annual income tax on the sums that the association puts into the fund

*Unfortunately, the decision doesn't indicate how large the association must be in order to get corporation tax treatment. The Montana clinic had eight doctor-members when the case went to court (at present it has nineteen). Some tax consultants believe that even a small association of three or four doctors with, say, three non-doctor employes could qualify; but others aren't so sure.

for him. In addition, the trust that manages the fund may invest and reinvest the money, and its earnings will be tax-free. (The accompanying table shows the difference such tax benefits can make in the growth of an individual pension fund over a period of years.)

¶ When the doctor retires, he can get his pension money in a lump sum (and pay a relatively low, long-term capital gains tax on it). Or he can take it in the form of an annuity (and, unless he has considerable additional income, pay little, if any, annual tax).

What do such concessions add up to in dollars and cents? Well, suppose that a doctor-member of the Montana clinic is enrolled in the pension plan at the age of 35. Suppose, too, that his salary is $800 a month, plus a share of the net profits.

A Sample Case

Each year, the association will pay a specified amount—$2,000, say—into the pension fund for him. When he retires at 65, after thirty years of this arrangement, here's what he'll get:

1. A pension of $360 a month *for life*; and

2. Paid-up life insurance policies that have a face value of $36,000 (and a cash-surrender value of about $28,000).

It's true, of course, that the association accumulates its pension fund by setting aside money that the doctor would otherwise receive as his share of the partnership income. But because the fund is tax-exempt, it can accumulate about *twice* as much as the doctor himself could with equivalent sums over the same period.

Under their association arrangement, the Montana doctors qualify, too, for all other tax benefits allowed by law to employes. For example, they can draw up to $100 a week in nontaxable sickness benefits. Their families can get nontaxable death benefits of up to $5,000 from the clinic. And, of course, they're covered by Social Security.

How About You?

Can other groups now follow Kintner's lead without fear of challenge from the Federal Government? There's a dual answer to that question:

1. Groups located in the seven Western states and three territories under the jurisdiction of the Ninth Circuit Court of Appeals* have full legal right to set up tax-favored pension funds. Only condition: They must be organized as associations rather than as straight partnerships.

2. Groups in other parts of the country are in a less fortunate position, since the court ruling doesn't have the force of law for them. So the Government [MORE ON 277]

*Arizona, California, Idaho, Montana, Nevada, Oregon, Washington, Alaska, Guam and Hawaii.

XUM

Socialized Medicine Comes to Sweden

Here's an on-the-scene report of what Europe's newest compulsory health insurance plan means to 5,000 physicians—viz., more work, less money

By Gustav Svensson

STOCKHOLM

● While President Eisenhower has been urging reinsurance on the U.S. Congress, Sweden has been taking the plunge from voluntary to compulsory sickness insurance. Our new departure goes far beyond what the Administration wants in your country, of course. But many doctors here in Sweden have observed that each small step leads inevitably to the big one.

So it seems a good idea to tell America's physicians about our plan: how it grew, how it works, how it affects the medical profession.

For a prior hint of the answer to that last question, listen to Dr. Dag Knutson, president of the 5,000-member Swedish Medical Association:

"We doctors aren't happy about the program. On the contrary, we're distressed by it. More than that, we're skeptical as to its results."

As I've implied, socialized medicine in Sweden didn't just pop up out of nowhere. The fact is that, while most

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MR. SVENSSON *writes in English but is himself Swedish. He's with the Associated Press Bureau in Stockholm.*

Swedish M.D.s regard the new compulsory scheme as a drastic one, the Government has had its hand in health insurance programs ever since 1891. At first, it helped finance a few independent, voluntary plans. Then it drew up rules of conduct for them. Gradually the subsidies grew, and the rules with them. Result: In 1947, the Riksdag (Parliament) adopted the present compulsory health insurance law.

For eight years the Riksdag delayed voting the necessary funds to put the scheme into force. Finally, however, on Jan. 1, 1955, the law took effect.

Nearly All Covered

What's new about the 1955 program is that it's both compulsory and comprehensive. Until this year, 60 to 70 per cent of Sweden's 7 million people were covered voluntarily by some form of Government-supported sickness insurance. But now, everyone's included; and everyone who can pay must do so.

Well, almost everyone. There's one able-bodied exception: King Gustav Adolf VI, exempt because of his position.* Other exceptions: Those who've been hospitalized or imprisoned for two years or more, and those over 67 who are drawing old-age pensions. (The old-age pensioners are eligible for all benefits, but they don't have to pay.)

*Queen Louise has to pay *her* premiums, though—just as her subjects pay theirs. She holds card No. 231103 and is registered as a "housewife."

Surprising as it may seem in a compulsory sickness insurance program, the Swedish patient *does* have the right to choose his own doctor. The doctors insisted that the right of free choice be written into the new law. But at that point freedom stops.

Everyone over 16 (even the foreign resident) who has a taxable income of $233 or more and who is not among the few exceptions noted must pay the national health insurance premiums. Each is taxed between $11 and $35 a year, according to his income. This amounts to 44 per cent of the cost of individual coverage. Employers pay 27 per cent of the rest; the Government, 29 per cent. Estimated total cost to the nation in 1955: $144 million.

Insurance benefits cover medical care and loss of income due to illness. More specifically, each member of the plan is entitled to:

¶ Free hospital care up to two years in a public ward, including operations and other treatment.

¶ Payment of 75 per cent of doctors' fees.

¶ Free medicines, like insulin, if essential to the treatment of diseases designated as chronic or serious.* For other medicines pre-

*The list of "approved" diseases, drawn up by the Swedish Medical Association, includes pernicious anemia, diabetes mellitus, diabetes insipidus, myxedema, Addison's disease (syndrome), parathyroprival (parathyroid) tetany, sprue, myasthenia gravis pseudoparalytica, glaucoma, epilepsy, bronchial asthma (chronic), tuberculosis, cancer (of breast, ovaries, prostate gland, or testes), and Parkinsonism.

scribed by a physician, a 50 per cent reduction in price is allowed after the first 60 cents.

¶ A $52 bonus to all mothers for childbirth ($80 for multiple births), plus free obstetrical attention at home or in the hospital, where public ward confinement is also free.

¶ Payment of all or part of travel expenses for both doctor and patient.

¶ Compensation for loss of earnings due to illness, ranging from 60 cents to $4 a day—and for as long as two years.

¶ Additional cash allowances for children under 15 during the time the wage-earner is ill or the mother hospitalized.

¶ Compensation for industrial injuries, paid on the same basis as sick benefits, for the first ninety days (after which, workmen's compensation laws apply).

The M.D.s' Reaction

What does all this mean to the nation's physicians? For most of them, it means more work at lower fees. For some who were in private practice, it means a state salary for the first time. [MORE ▶



"FREE CHOICE OF DOCTOR is our last remaining freedom," says Dr. Dag Knutson, president of the Swedish Medical Association and critic of his country's health insurance program.

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The Swedish Medical Association has been "violently against this compulsory health plan from the beginning," says Dr. Knutson. "We felt that voluntary sickness insurance was developing very satisfactorily in Sweden. Two-thirds of the people were covered. Besides, everybody in need of hospital care or other medical attention was already entitled under existing laws to the best treatment, whatever his economic resources."

Fees Are Lower

One very natural complaint of the doctors: Fees in general are now considerably lower.

"Our fees were always modest, compared with those in other countries," the S.M.A. head points out. "Though the average for a first office visit was $3 to $5, it dropped to $2 for subsequent visits—and in some cases even less."

Now the law has indirectly sliced such charges by about 25 per cent. G.P.s are free to set their own fees, but the Government allowance tends to become the fee actually paid.

'We're the Buffer'

What other features of the plan most disturb the medical profession? Dr. Knutson stresses three:

1. Today's Swedish physician feels he has been put in the middle. The profession must now perform what Dr. Knutson calls the "delicate and difficult" task of acting as "intermediary between the patient and the state insurance institution. So we're the buffer. We take the knocks."

2. Red tape is a constant source of irritation: "We're being snowed under by blanks and forms—which, alas, the medical association helped to draft. We've got twice as much paper work to do as before."

3. There's a growing danger of widespread misuse of the newly granted benefits. "Cash benefits, for instance, are exempt from taxes and are fairly high. So there are already cases of possibly malingering patients who earn as much, or nearly as much, by being sick as they'd earn by working," explains Dr. Knutson. (The Government, incidentally, is aware of this problem and has announced its intention to come to grips with it.)

Nobody's Sure Yet

So far, Sweden's doctors and Government officials have found one area of agreement: They refuse to predict the future of the health program. The S.M.A., for one, says it needs more time to study the full significance of the change.

"Although we have opposed the compulsory insurance plan consistently," says Dr. Knutson, "we have, since its adoption, cooperated loyally. We're still trying to eliminate the worst mistakes—but we don't know what's going to happen."

Referring to British and Belgian precedents as "frightening," he says he hopes Sweden can at least

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avoid the hysteria that in other countries seemed to impel a rush for eyeglasses and false teeth.

There's certainly reason for *some* optimism: Sweden's national health standards have long been high; the average life span there is now 69 years; and the infant mortality rate is the lowest in the world.

But a number of individual physicians insist on viewing their personal futures with alarm. "I'm being worked to death," one of them told me the other day. "It's not only the red tape. My work load has doubled since last year. I wouldn't be surprised if it tripled before long."

How would you in America like to have a tripled work schedule forced on *you*? END



"There's not a thing wrong with you . . . Come back again tomorrow!"

These New Insurance Forms Will Save You Time

You shouldn't have to fill out many book-length health and accident reports in the future. The first of several shortened, simplified forms has just been approved for general use

By Thomas Owens

● You'll soon be spending a good deal less time filling in patients' health and accident insurance forms.

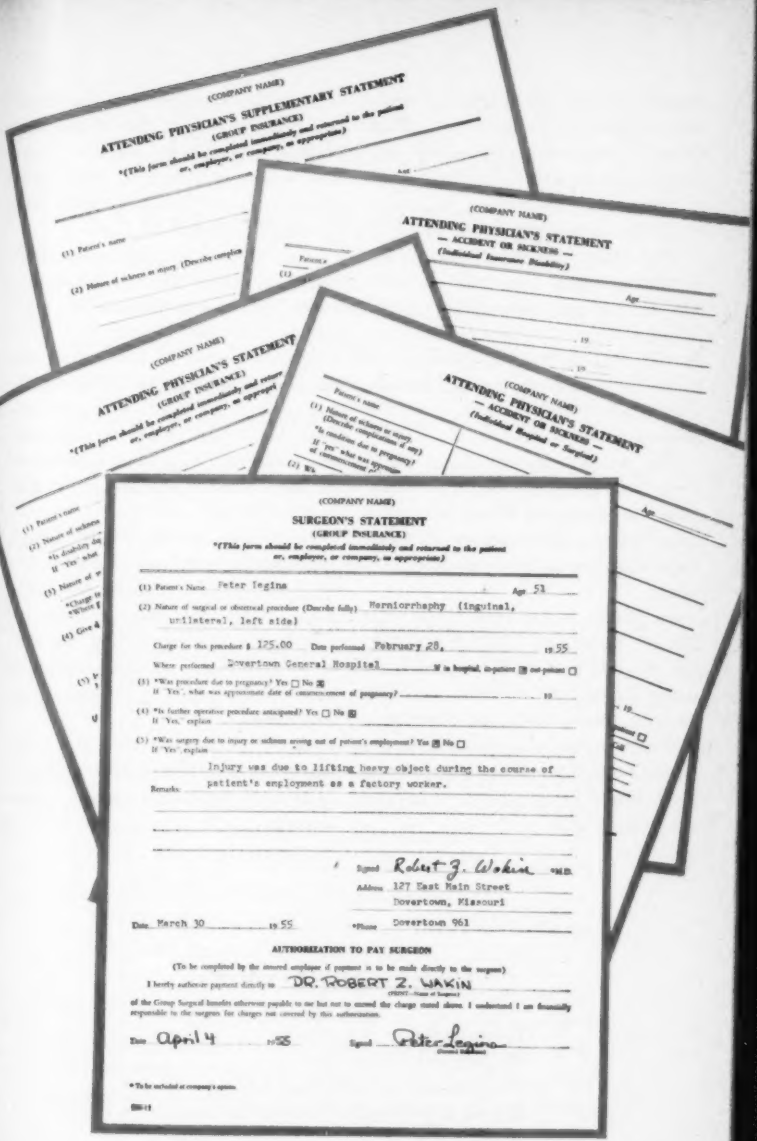
Two years ago, organized medicine and the health and accident insurance industry united in a joint effort to try to trim down the forms used by the commercial carriers. They succeeded so well that a marked cut in the average doctor's paper work is now in prospect.

Most health and accident insurance companies (though not quite all) have agreed to cooperate by using the resulting set of simplified, uniform claim forms. So no more will such carriers ask you to execute the long-drawn-out blanks or the variety of blanks that have been so common in the past.

The cut on the opposite page shows in detail the first of the new forms (GS-I) to be approved by the A.M.A. and the Health Insurance Council (which rep-

BREVITY AND SIMPLICITY are chief features of new forms. ► One type (here filled in with sample report) is already being used. The four others (tops shown) should be ready soon.

XUM



(COMPANY NAME)

ATTENDING PHYSICIAN'S SUPPLEMENTARY STATEMENT

(GROUP INSURANCE)

(This form should be completed immediately and returned to the patient or, employer, or company, as appropriate)

(1) Patient's name

(2) Nature of sickness or injury. (Describe complica

(COMPANY NAME)

ATTENDING PHYSICIAN'S STATEMENT

— ACCIDENT OR SICKNESS —

(Individual Insurance Disability)

Age

(COMPANY NAME)

ATTENDING PHYSICIAN'S STATEMENT

(GROUP INSURANCE)

*(This form should be completed immediately and return or, employer, or company, as appropri

(1) Patient's name

(2) Nature of sickness

*Is disability du
If 'Yes' what

(3) Nature of

*Charge to
*Where t

(4) Give d

(5) P

(COMPANY NAME)

ATTENDING PHYSICIAN'S STATEMENT

— ACCIDENT OR SICKNESS —

(Individual Hospital or Surgical)

Patient's name

(1) Nature of sickness or injury (Describe complications if any)

*Is condition due to pregnancy?
If 'Yes' what was approximate date of commencement of pregnancy?

(2) Was

Age

(COMPANY NAME)

SURGEON'S STATEMENT

(GROUP INSURANCE)

(This form should be completed immediately and returned to the patient or, employer, or company, as appropriate)

(1) Patient's Name Peter Legina Age 53

(2) Nature of surgical or obstetrical procedure (Describe fully) Herniorrhaphy (inguinal, unilateral, left side)

Charge for this procedure $ 125.00 Date performed February 28, 19 55

Where performed Dovertown General Hospital If in hospital, in-patient ☒ out-patient ☐

(3) *Was procedure due to pregnancy? Yes ☐ No ☒
If 'Yes', what was approximate date of commencement of pregnancy? 19

(4) *Is further operative procedure anticipated? Yes ☐ No ☒
If 'Yes,' explain

(5) *Was surgery due to injury or sickness arising out of patient's employment? Yes ☒ No ☐
If 'Yes' explain

Remarks: Injury was due to lifting heavy object during the course of patient's employment as a factory worker.

Signed Robert Z. Wakin M.D.

Address 127 East Main Street
Dovertown, Missouri

Date March 30 19 55 *Phone Dovertown 961

AUTHORIZATION TO PAY SURGEON

(To be completed by the insured employee if payment is to be made directly to the surgeon)

I hereby authorize payment directly to DR. ROBERT Z. WAKIN (PRINT - Name of Surgeon)

of the Group Surgical benefits otherwise payable to me but not to exceed the charge stated above. I understand I am financially responsible to the surgeon for charges not covered by this authorization.

Date April 4 19 55 Signed Peter Legina (Insured Employee)

* To be included at company's option.

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resents most of the health and accident insurance companies). This form—for reporting general surgery claims—has already been distributed to insurance companies, so some M.D.s are actually using it now.

The other simplified forms—for reporting other types of claims—will be put into use within a few months, as soon as they get final approval. (Only the top portions of those forms are shown in the cut, since their detailed wording is still subject to revision.)

For years, doctors have been complaining about the hours they have had to spend filling out insurance forms. How amply justified their complaints were is now evident:

In planning the new forms, the Health Insurance Council committee found that "companies were using *twenty-six* different ways to inquire about diagnosis, *thirty-four* different ways to inquire about the present condition of the patient, and *forty-two* different ways to inquire about prognosis."

Sporadic attempts were made in the past to reduce the complexity of insurance forms. But the problem was so widespread that really effective action could be taken only on a national scale.

The all-out simplification effort began in April, 1953. The logical body to represent the insurance industry was the Health Insurance Council because its more than 400 member companies write about 85 per cent of all the health and accident insurance issued by commercial carriers. The A.M.A. Council on Medical Service represented organized medicine.

Speaking of the new forms, Howard Brower, assistant secretary of the Council on Medical Service, says, "They should save time and money for the companies, the doctors, and the patients—without in any way prejudicing the processing of claims."

A G.P. who inspected the forms puts it still more enthusiastically: "Greatest headache remedy since aspirin." END

Unanimous Verdict

The doctor was acquitted;
He pleaded self-defense.
The patient had called at 3 A.M.
For an appointment two weeks hence!

—NATALIE SOREF

The Doctor Draft: Alive and Still Kicking

If you're under 38, the Defense Department may be sizing you up for a uniform—at least for the next two years. After that, most likely, the military pressure will ease up a bit

By John Brooks

● Let's face it. Those encouraging things people were saying in Washington about the expected demise of the doctor draft just aren't so.

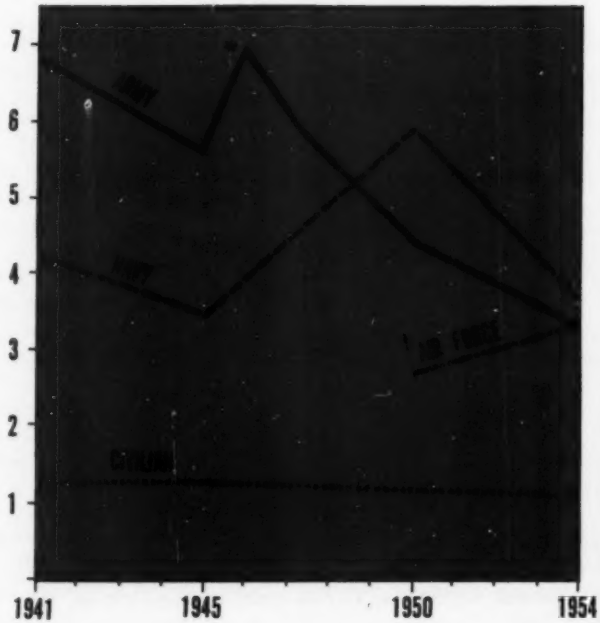
The Pentagon had an idea—but not for long—that the law could be allowed to die a natural death when its time came at the end of June. But now the brass is saying, "Sorry. We'll have to keep it alive for another two years."

So if you're under 38 and have had no military service, there's a good chance of your being called up under the present regulations. To help make sure you will be, the Defense Department has formally asked Congress to extend the doctor draft to July 1, 1957; and the gentlemen on Capitol Hill are expected to comply.

Why the shift in Pentagon policy? Dr. Frank B. Berry, Assistant Secretary of Defense, gives the answer:

"Until recently, we thought we'd be able to get enough doctors through the regular draft so that we wouldn't have to ask for an extension of the special law. But now we find that, for the next two years, we *can't* get enough eligible M.D.s without taking just about everybody at the

Military M.D. Ratio Still High



The chart above shows the number of physicians per 1,000 persons in each branch of the military and in civilian life. The *combined* ratio of medical officers to military personnel (all branches of the service) has dropped from a wartime high of 6.5:1,000 to a current 3.2:1,000. During the same period the ratio of physicians per 1,000 civilians has remained almost constant. The jump in the Army ratio in 1946* is more apparent than real since enlisted men were demobilized at a faster rate in 1946-47 than were medical officers. Air Force figures† before 1950 were combined with the Army's.

interne level. And that won't do. The services need specialists, too."

While the armed services will be cut back somewhat, as recently recommended by President Eisenhower, manpower officials are getting harder to convince that anyone needs a deferment. This means a general tightening up of policy as far as physicians are concerned, too.

Pentagon Goals

The reason is, of course, that the supply of medical personnel is being scraped from the bottom of the barrel. The Pentagon figures it must keep the number of medical officers at a high enough level to ease through the current "lukewarm" war. And that level is to be 3.2 doctors per 1,000 troops (compared with 3.7 two years ago and 6.5 at the height of World War II).

Incidentally, the ratio of doctors to civilians is around 1.2. So the services are now soaking up medical personnel at three times the civilian rate.

With an armed force estimated at 2,940,000 men, the services need at least 9,400 doctors every two years to maintain the 3.2 ratio. About 3,400 of these can be expected to come from the regular corps. The other 6,000 must be furnished by the doctor draft.

What about the *young* fellows in medicine? some will ask. The Government hasn't overlooked them. Says Dr. Berry (himself a veteran of two world wars): "Over the last few years, we've taken younger doctors, and tried to protect the older ones. But now the supply of younger doctors is running out. We don't think we can fill the services' needs entirely from the men not long out of medical school."

Take, for instance, the 1955 crop of medical school graduates. Of these, Dr. Berry says:

¶ 15 to 17 per cent will fail their physicals (ulcers and psychiatric problems are the commonest reasons for deferment);

¶ 40 per cent can be discounted for previous military service.

Fewer Veterans

"Though there will be fewer veterans in succeeding classes," Dr. Berry says, "we can't count on getting as many as 3,000 military medical officers from the 1955 interne group."

Of the class of 1955, about 4,100, or 60 per cent, will have had no military service. But by July, 1956, when the same class completes its interneship, the services will need 4,300 new medical officers.

Once the doctor draft is extended to 1957, the Defense Department plans to call up some 500 to 700 doctors, now in Priority 3, who were deferred during the last war as essential or physically unfit.

Physical deferments in this priority will be increasingly hard to get. So if you're now in Priority 3 and were once rejected as 4F, don't assume that you'll continue to be

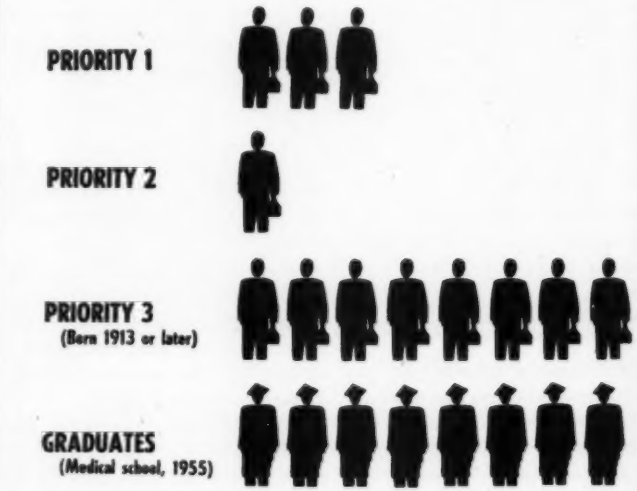
classed as 4F. "Physical requirements for doctors," says Dr. Berry, "have been dropped very low."

Take the case of a doctor who recently reported for Navy duty in a wheelchair. Officials concluded that his disability, even if permanent, would not interfere too much with his ability to practice medicine.

As one wag put it: "If you can walk, there's a good chance they'll take you." His buddy chimed in: "You mean if you *can't* walk."

The other classifications? Well, if

Available for the Doctor Draft



Each symbol represents 500 men

Defense Department spokesmen say that most doctors in Priority 1 and 2 will be called up by June 30. This means the military will have to dip further into the supply of older physicians in Priority 3.



EVEN IF YOU CAN'T WALK, the doctor draft may get you. The Navy recently took a doctor in a wheelchair. He couldn't stand up, but he could practice medicine, officials explained.

you're in Priority 4—with at least seventeen months' active service—you probably won't be called, short of full mobilization.

If you're in Priority 1 or 2—i.e., you had a World War II professional training-deferment or Federal training aid—the chances are you're pretty near induction.

No Basic Changes

(Theoretically, of course, you're still subject to call if you're under 50. Upcoming Congressional action won't basically alter standing legislation.)

A continuing study, begun in 1952 by the A.M.A.'s Council on National Emergency Medical Service, indicates that half the time of medical officers is given to care of service personnel; about one fifth to care of servicemen's dependents; and the rest to training, administration, and similar functions. Dr. Berry retorts that since the military is a world-wide operation, there's bound to be some waste.

Even so, Government medical chiefs are hopeful that they can cut waste and further consolidate personnel and facilities. Already, much has been accomplished by the joint work of military, medical, and civilian committees.

Some physicians charge that servicemen are often pampered by over-hospitalization—a situation that re-

sults in wasted attendance. One estimate, advanced by a Hoover Commission group, put hospital in-time for an uncomplicated service appendectomy at two to three times the civilian average: 19 days for Army personnel, 22 days for Navy personnel—as against an 8-day civilian average.

"Complaints like this," says one M.D., "don't make the doctor draft any easier to take."

Future Planning

Defense chiefs feel they must call up older physicians in order to meet their quota and be sure of a reasonable number of mature men with specialist training. But they make it plain that they don't intend to rely on the doctor draft as the only means to that end. The ultimate aim is to get military medical manpower on a self-sustaining basis and to devise methods of getting more physicians into the services without legislation. Here's what's planned:

¶ A group of 700 to 900 internes would be deferred each year for further residency training, as recommended three years ago by the National Manpower Council. ("If they're not deferred, where are we going to get the specialists we need in the future?" asks Dr. Berry.)

¶ A minimum draft of older physicians would be used to maintain a training reserve for future needs.

This, Dr. Berry suggests, is the only way "to attain a position where a doctor draft is no longer needed." He thinks that approximately two years will suffice to get the program working fully.

A helpful factor here is the increase in the rate at which medical schools are turning out graduates. The number of graduates climbed from 5,097 in 1940 to 6,861 in 1954. No slackening of this trend is expected.

Administration hands agree that medical school graduates alone can never entirely solve the problem. But if present armed strength is maintained (and this is a delicate assumption), then the greater the increase in non-veteran graduates, the more men in each class can be used in service.

Scholarship Plan

Another aid in achieving a self-sustaining medical manpower program—and thus the eventual death of the doctor draft—is the Defense Department's scholarship plan, now before Congress, to provide 300 additional physicians a year in the armed services. A scholarship would pay all tuition fees, plus a monthly living allowance, against year-for-year military service, with a minimum three-year hitch for scholarship holders.

Unfortunately, these steps won't pay off immediately in reducing pressure on older doctors. So for the time being at least, they'll have to live with special draft legislation—labeled by many as "discriminatory" and "immoral." END

XUM

'I'm *Against* Delegating Work'

MEDICAL ECONOMICS ***feels that this rebuttal to a recent article posts a valid warning but is exaggerated. Nevertheless, it may well help other doctors to clarify their thinking on an important question of practice management***

By Robert W. Johnson, M.D.

● You've heard the story of the business tycoon who dropped a $10 bill and saw it flutter to the ground, but kept right on going. He figured it just wouldn't pay him to take the time to stoop over and pick it up.

Silly? Well, no more silly than the doctor whose time is too valuable to spend taking case histories or doing intravenouses and who therefore lets his aide handle most such "details" for him.

I write this after reading an article by management consultant Millard K. Mills in February, 1955, MEDICAL ECONOMICS. Mr. Mills, I admit, has some good ideas about delegating work. And he shows very capably how the doctor can save energy, time, dignity, and money by allotting certain chores to his employes.

Much of what he says makes sense. For example, you wouldn't want to see a doctor pounding out his own reports while patients fretted in the waiting room and the receptionist polished her nails.

But Mr. Mills carries it too far. Do the doctors in his area *really* believe their patients "welcome the chance to

EDITOR'S NOTE: "Clearly, some of these ideas are controversial," the editors said in a preface to our February article on delegating work. "Not every physician will want to apply them to the same extent."

Now here's an article by a physician who doesn't want to apply them to *any* extent. Why?

Is he really against the idea of delegating office routine to well-trained assistants? We don't think so. We think he's against *perversions* of the idea, and we're publishing his article as a useful reminder of those perversions.

It is obviously not good management, for example, if the doctor allows a "palace guard" to become a barrier between himself and his patients; or if he permits a "virginal aide" to indoctrinate expectant mothers; or if he lets his Girl Friday "pontificate about health"; or if he turns over *all* history-taking to nonmedical assistants; or if he "becomes a slave to his own staff."

That's not delegating work. That's abrogating responsibility! Dr. Johnson seems to suggest they're the same thing.

They don't have to be. "In any well-run medical office," as our February article pointed out, "the doctor controls policy; the aide executes details." Remembering this, you

contribute to their own medical records" by filling in forms themselves, or by telling all to an aide? I wonder!

All arguments for delegating work seem to me to rest on the doubtful assumption that every M.D. has a waiting list of patients clamoring to see him and that they

can enjoy the accompanying article without taking its exaggerations too seriously.

This one, for instance: "All arguments for delegating work seem to me to rest on the doubtful assumption that every M.D. has a waiting list of patients clamoring to see him and that they can't get in because the doctor is busy typing monthly statements or dusting the furniture . . ."

This clever caricature almost obscures the fact that many an M.D. *does* have a waiting list. Let him look at his appointment book for tomorrow and the next day. Is it a "doubtful assumption" that some of these patients could come in today? Let him look at the people waiting in his reception room. Is it a "doubtful assumption" that these people would prefer to be seen with less delay?

The doctor who delegates can cut down both waits. What's more, he can do it without permitting the perversions described here. We've seen it done. And we suspect that more will soon be doing it.

In our view, therefore, the accompanying article does not really undermine the basic concept of delegating work. In a way, it bolsters that concept; for it dramatizes the pitfalls so vividly that readers are likely to delegate more carefully and, therefore, more successfully.

can't get in because the doctor is busy typing monthly statements or dusting the furniture. Thus, since the physician's time is worth ten times as much per hour as the aide's time, he should tend to his patients and let her do the minor jobs.

But I know—and you know—that

in practice no doctor refuses to take care of a patient so that he can, instead, take care of a clerical or housekeeping chore. So actually the M.D. isn't offered the choice of either typing a letter himself *expensively* or paying an *inexpensive* secretary to do it for him.

A far more likely choice is this: Should he sit on his gluteus maximus reading "Tonics and Sedatives" while paying a girl $1.25 an hour to open his mail? Or should he open it himself?

Suppose that, dollars-and-cents-wise, it *were* more profitable to let the aide take a history, perform a refraction, administer an intravenous. And suppose she could do such things, and could thus save her employer's valuable time. Even then, in terms of public relations, it would be unwise to delegate those tasks to her.

Let's get more specific. Let's talk, for instance, about the morning mail. It's sometimes recommended that the secretary open all envelopes and decide which communications to handle herself, which to give the doctor, and which to throw away.

Set up that system, and you'll have a palace guard with a vengeance. Not me. No girl knows what advertisement might happen to interest *me*, or what charity might, for certain personal reasons, touch

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my heart. I want to decide myself whether I'm too busy to accept a speaking engagement or whether to answer a form letter.

If the girl just slices open the envelopes, O.K. But if she starts screening the mail, I say, "No, thank you. I'm a big boy now and can do my own deciding." Maybe the President of the United States does get 50,000 letters a day and can't see them all. But I'm not in that class yet.

Advice From Aides

Some doctors apparently let their aides give professional advice. Mr. Mills, for instance, says that in a number of offices in Iowa the clinical aide helps indoctrinate OB patients, seeing them "before the doctor does, inviting questions and answering all she can."

Once more, not for me! If a pregnant woman can't get the information she wants from her doctor, she'll get her old wives' tales directly from an old wife. No virginal aide—not even an office nurse—is going to tell *her* the facts of life.

"Talk isn't cheap," says Mr. Mills, "not when the doctor takes twenty minutes to explain something a clinical aide could explain just as quickly." But if an optometrist—after four years of professional school—tries to tell people about eye care, most of us holler bloody murder.

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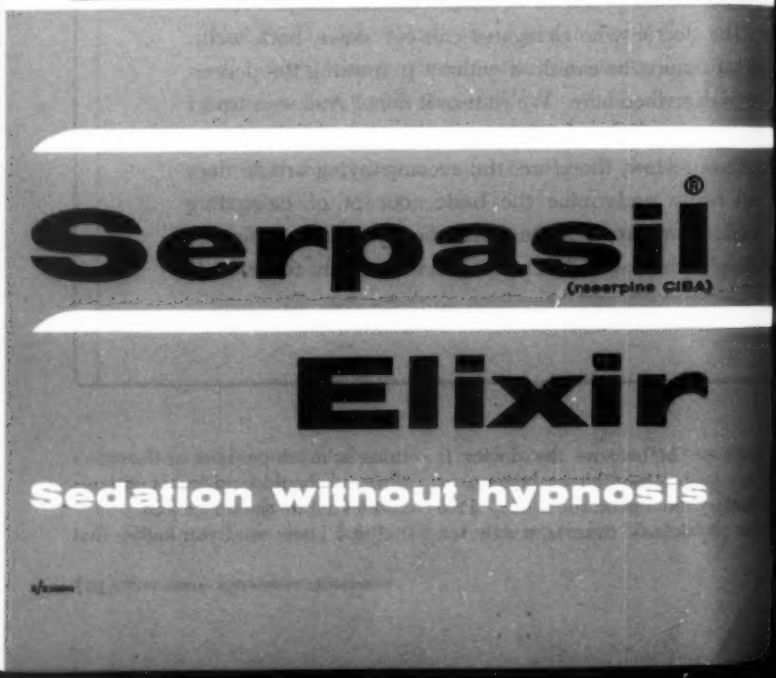
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A convenient dosage form for every medical requirement.

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Can we consistently allow a less well-trained office aide to pontificate about health?

When a patient wants the physician to explain something and the doctor says, "Ask my secretary" . . . well, the patient has a word for it. The word is "brush-off." Delegate like that, and you *will* save time—lots of time—right in the middle of office hours.

Sure, the doctor is important. But let him not become too important to communicate with the people he treats.

A History Lesson

One of the major duties assigned to aides—clinical and otherwise—these days is history-taking. The theory is that any literate person can ask a patient whether he's ever had measles; so why should the M.D. fritter away *his* valuable time asking such questions?

There are a lot of things wrong with this argument. In the first place, taking a medical history is *not* just a matter of recording data. You have to know *how* to ask a question. It takes considerable finesse to ask a patient whether, for example, he drinks too much.

Also: There are a number of items in the medical history that the average patient will confide *only* to a physician. If the doctor is too important to take his own histories, what happens? Two things: The aide may get an incomplete history. And the patient may decide to switch M.D.s rather than return to an office where a nonmedical assistant is allowed to pry into his intimate life.

Still more important: History-taking is an inherent part of medical practice. Good medical judgment consists largely in the canny exploitation of little clues that emerge from a history. The fact that a patient's headache is one-sided suggests an inquiry into hereditary factors. The fact that the headache is aggravated by straining at stool suggests the need for an inquiry about vision.

I'm convinced that no aide is bright enough or well trained enough to know all the bypaths of history-taking. To let her do the job is both tactically bad and professionally ill-advised.

'The Personal Touch'

One of the commonest gripes among patients today is that doctors no longer seem to be *personally interested* in them. The patient wants less mechanization, fewer barriers between himself and his physician, more of the personal touch. Yet Mr. Mills writes approvingly of a certain G.P. who employs a secretary's part-time helper as a "telephone solicitor." Here's how he describes this person's duties:

"She works from a list . . . Placing most of her calls in the evening, she makes sympathetic, low-pressure inquiries about the reasons for payment delays. Her efforts have

Postoperative Diets



Postoperative diets are complicated many times by the patient's loss of interest in eating. Yet the need for high protein food is essential in the dietary of postoperative patients.

Nitrogen balance can be maintained, wound healing enhanced, and convalescence shortened by a high protein diet.[1]

KNOX UNFLAVORED GELATINE is all protein . . . has no sugar . . . is in a neutral pH. range . . . low sodium . . . non-allergenic.

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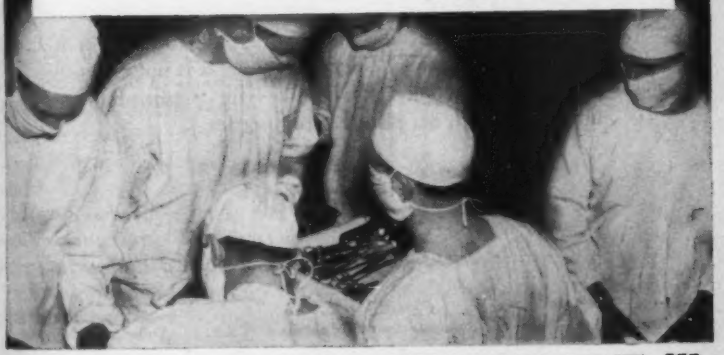
1. Co Tui, Minutes of the Conference on Metabolism, Aspects of Convalescence, Including Bone and Wound Healing. Josiah Macy, Jr., Foundation, 5th Meeting, Page 57, 1943.

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Hydrocortisone, 3 Antibiotics, 2 Decongestants

Indications: *acute rhinitis chronic rhinitis bacterial rhinitis allergic rhinitis nasopharyngitis*

Hydrocortisone (compound F)—the most effective anti-inflammatory agent

Hydrocortisone is so effective that, when applied topically, maximum therapeutic response is achieved with an extremely low concentration. This low concentration (0.02%) of hydrocortisone is one of the reasons why 'Trisocort Spraypak' produces none of the side effects commonly associated with systemic steroid therapy.

3 Antibiotics—effective against gram-positive and gram-negative bacteria

'Trisocort Spraypak' contains 3 antibiotics—gramicidin, polymyxin and neomycin—to inactivate those gram-positive and gram-negative bacteria commonly found in upper respiratory tract infections.

2 Decongestants—for both rapid and prolonged relief of nasal congestion

'Trisocort Spraypak' also contains 2 superior decongestants—phenylephrine hydrochloride and Paredrine† Hydrobromide—to provide *both* immediate *and* prolonged relief of nasal blockage.

Low cost: Despite the fact that 'Trisocort Spraypak' contains hydrocortisone, 3 antibiotics and 2 decongestants, it is not expensive.

Available: 'Trisocort Spraypak' is available—on prescription only—in convenient ½ fl. oz. plastic spray bottles.

'Trisocort Spraypak'

Smith, Kline & French Laboratories, Philadelphia

*Trademark
†T.M. Reg. U.S. Pat. Off. for hydroxyamphetamine hydrobromide, S.K.F.

Patent 2181845
Other patents applied for.

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brought in twenty times what the campaign costs. And the doctor doesn't even have to supervise; that's part of his secretary's job . . ."

Not in *my* office! And probably not in yours either. Can you dream up a better way of mechanizing the doctor-patient contact and of totally forfeiting the personal touch?

That Third Person

As a matter of fact, Mr. Mills can. He seems to delight in finding ways for a third person to interpose herself between patient and doctor. He cites, for instance, one physician's aide who (in addition to her other key duties) not only types her employer's letters but also composes 'em—and signs the doctor's name—all "on her own."

"She turns out a steady stream of thank-yous for referrals . . . and so-sorry notes," says Mr. Mills. Parenthetically, he points out that "the doctor periodically reviews file copies."

How many M.D.s reading this article are willing to stand up and be counted among those who like their secretaries to do such things? As for me, I want to see what I'm supposed to have said before any formidable female Friday goes and drops it irrevocably down the mail chute.

I don't know about *you*; but I like to vary my way of thanking colleagues for their referrals. The tone of the thank-you depends on my relationship with the referring doctor; and no beauteous alumna of a business college can read my mind.

The doctor who delegates to such an extent becomes a slave to his own staff. He's afraid to make an appointment without getting a clearance from his secretary. If she takes a day off, he can't find anything in his own file cabinets.

In fact, if she isn't around, he doesn't know how much money is in the bank; he doesn't even know who of his patients has paid and who hasn't.

Come to think of it, all such a man really is at this point is a technician working with a bevy of other technicians, secretaries, nurses, and receptionists. They spoon-feed him all right; but they allow him to assume all legal responsibility for their mistakes. [MORE ▶



Mr. Mills even talks about a two-class system: If the nurse does the refraction, $10; if the doctor does it, $15. Does this mean, I wonder, that every office should segregate patients into two groups: first-class patients and second-class patients? And should the patient be asked to take his choice? Like this, for example:

"Mr. Smith, you need another allergy shot. Do you want me to give it at $4? Or will you take Miss Jones at $2?"

Sounds ridiculous? It is. It reminds me, in reverse, of the man with a priapism. In the doctor's absence, the lovely and lusty receptionist took care of him fine. His priapism was reduced delightfully. He had never had it so good. The charge: $15.

A week later, the priapism—and the patient—returned. This time the doctor was in. He reduced the priapism by putting the priapus under a stream of cold water. The charge was $3.

"Oh, well," sighed the patient, as he left the office, "you get what you pay for."

How It All Began

Don't blame the experts for backing us physicians into this corner. We asked for it. We kept complaining that the practice of medicine was too bogged down in red tape. We wanted someone else to do "administration" for us.

"You poor dear," said the nurse. "Let *me* take the blood pressures. *Your* time is too valuable."

"Let *me* put on the cast," suggested the helpful orthopedic attendant.

And "Let *me* test the hearing," offered the audiometric technician.

Then the chorus swelled:

"Let *us* save your precious minutes by doing the intravenous, taking the history, refracting the eyes, giving the massage, testing the urine, counting the blood cells, drafting the report, drawing the blood specimen, taking the X-ray, setting the fee, and telling the patient just what to do . . . "

We fell for it. And we're still falling for it. We're flattered that our amiable assistants are so eager to spare us any work. We're tempted to delegate more and more.

By and by, what happens? The camel is in the tent and the Arab is out.

Except in Federal installations, we've been squeezed out of hospital management, anesthesia, and fee setting. Blue Cross, Blue Shield, and health agencies generally are more and more firmly under lay control. "After all," the managers say, "you doctors are such valuable citizens, your time is so very, very precious, that you mustn't waste it on administration. Let *us* take care of all the tiresome details for you."

Not me.

I still have time to bend down and pick up that $10 bill myself.

END

You'll save your patients
a lot of anguish if you

Use Words They Understand!

By Joseph D. Wassersug, M.D.

● The patient's wife had come to the hospital staff office to ask about her husband. He'd been hospitalized for many weeks, and she was visibly upset.

"How did today's examination come out?" she asked.

"Oh, he's got stenosis of the right upper lobe bronchus," the resident told her.

Stenosis? Bronchus? Bewilderment clouded the woman's face. But before she could ask what the words meant, the resident hurried off.

It would have been an easy matter to explain that the patient had a slight narrowing of one of his bronchial tubes. Instead, a poor choice of words caused a lot of unnecessary worry.

A gynecologist once told me about an anxious patient who appeared in his office for a pelvic check-up. He examined her and told her she was perfectly well except for a "little redness at the tip of the womb," that would require a few office treatments. Only then did she confide the real reason for her visit:

Another doctor had told her she had an "erosion" of the cervix. She didn't know what "erosion" meant—and she feared she might have cancer.

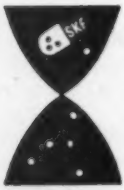
Both physicians meant the same thing and prescribed the same therapy. But the second doctor won the patient because he used simple language that did not alarm her.

Another good word to avoid is "rheumatism." Almost

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No. 1  & No. 2 

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*T.M. Reg. U.S. Pat. Off.
Patent Applied For

invariably, when a diagnosis of rheumatism is made, the patient pictures himself as a deformed, wheelchair invalid. If I *must* use the term, I'm careful to use it with qualifications that will keep him from becoming too disturbed.

Then there's the word "lesion." We hear it so commonly in medical discussions that we often carry it over into talks with patients. Yet few of them understand it. So it's wise, I've found, to stick to such simple words as "spot" or "condition."

Rx for Heart Trouble?

A well-known cardiologist says he never uses the word "angina" in front of patients. He deplores the number of people who have become psychoneurotics not because of angina itself but through *fear* of it. Instead of "angina," he generally says: "You have a temporary narrowing of one of the blood vessels of your heart."

Actually, there are quite a few broad, general euphemisms that serve a useful purpose in talks with patients. Take "congestion," for example. Everyone knows what "congestion" means. A G.P. tells me that when he first started practice he wondered why his colleagues used this word so often when talking with patients they were treating for cardiac failure, bronchitis, and the like. Today, this man himself finds "congestion" a most useful term.

Another good word is "inflammation"; here, too, we have a commonly accepted term that can take the place of such patient-worriers as "bronchiectasis" and "endometriosis." For the word "conjunctivitis," try substituting "inflammation of the eye."

In using these medically-almost-meaningless words, you'll of course guard against the habit of sloppy thinking: Your diagnosing will continue to be done in precise medical terms; only when "translating" something for the layman will the elementary words be used.

Before discussing bodily functions or sexual matters, it's a good idea to weigh your patient's intelligence. If he's educated enough to understand words like "defecation" and "orgasm," then use them if you want to. But if the chances are that he won't know what you mean, you may have to get colloquial. Stating the patient's problems in *his* language is what counts.

Some words are dangerous because they may imply neglect by another physician. One such word is "burn"—especially when applied to X-ray. This word conveys the idea of unintentional trauma and may even prompt a suit for malpractice. It's far safer to say "X-ray reaction," since that's usually what is meant.

There are two easy ways to convey ideas to patients without becoming over-technical. The first is with simple, mechanical analogies. Many a doctor finds it helpful, for instance, to liken the human body to a train or an automobile. [MORE▶

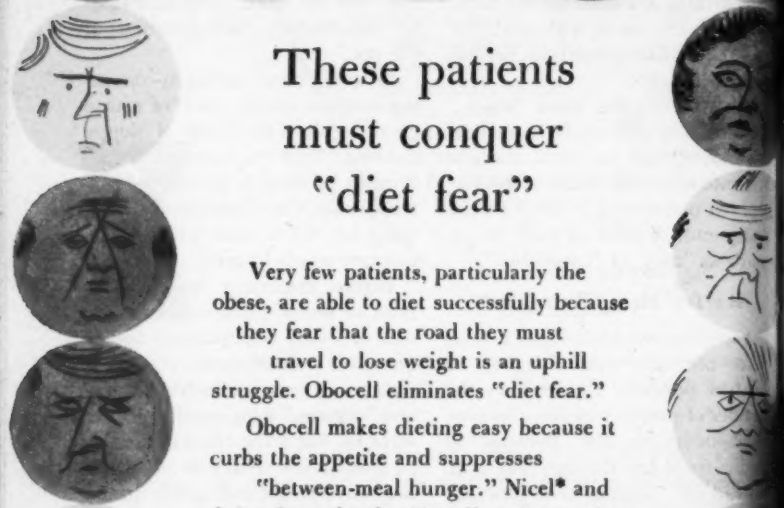
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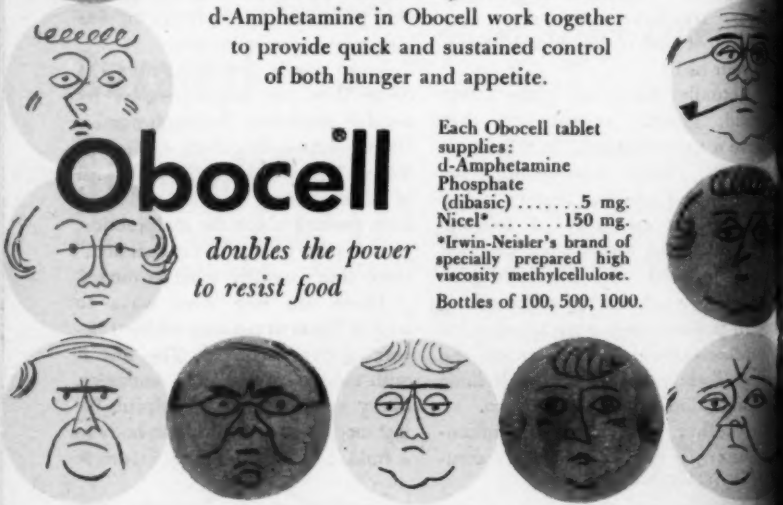


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1. Zelmen, S.: Arch. Int. Med. 90: 141, 1952.

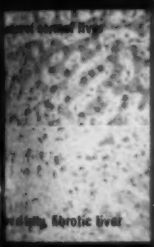
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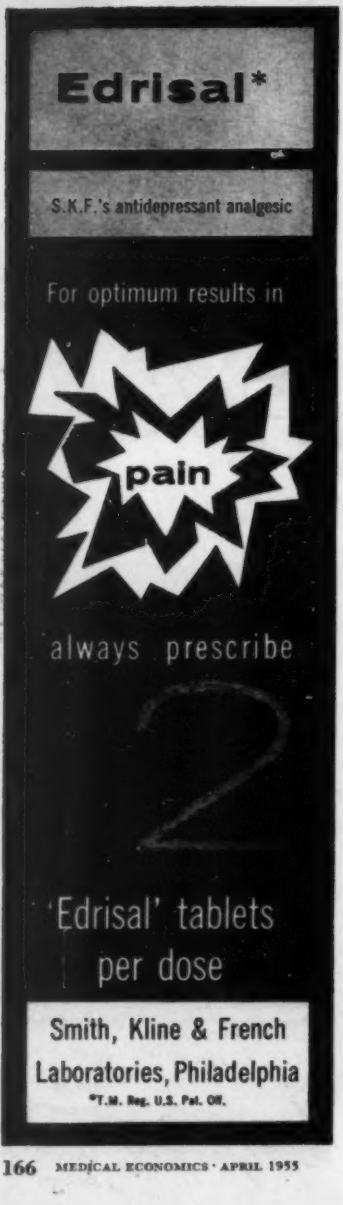


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Such analogies may fall short of depicting the whole truth, but they are convenient and time-saving. What's more, when the patient thinks about such an analogy, it may well remind him of the therapy you want him to follow.

Any ophthalmologist knows the value of comparing the eye to a camera or a window pane. How simple it is then to liken a cataract to a foggy lens or a corneal opacity to a dirty window!

Similarly, the cardiologist knows how readily the cardiovascular system may be described in terms of a pump with its distributing pipelines. And so on.

Another method of speaking the patient's language is to make a brief sketch. You don't have to be an artist to do this. In fact, your own line sketch may be better than the anatomical drawings in textbooks, because it's less cluttered.

Most anyone can draw a picture of the stomach and sketch in an ulcer. A spine can be shown on a series of squares placed one above the other. There is no anatomical region so complicated that it can't be presented graphically by a few strokes on a scratch pad.

Finally, in talking over medical matters with patients, I try to be brief and direct. Long-winded statements may be open to misinterpretation. The uncertainties of medicine being what they are, it's a wise M.D. who treads a path that both he and his patient are sure of. END



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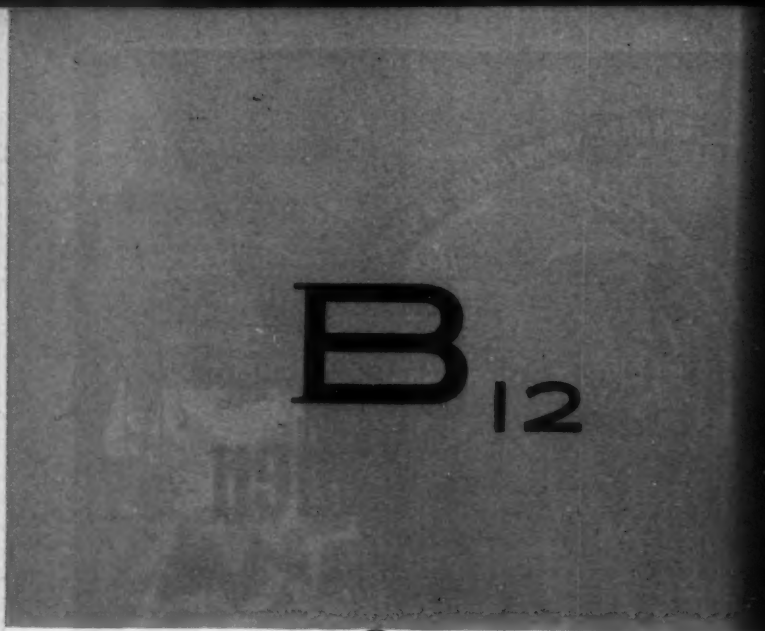
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1. De Lucia and Strosberg. Med. Times 82:1, p. 47. 1954.

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If You're Called to Testify

Here are pointers for the M.D. who may be summoned as a witness: his obligation to testify, his fees, pre-trial consultations, etc.

By Bernard R. Lauren, LL.M.

● For many doctors, testifying in court is a burden and a nuisance. That's understandable. The experience is likely to be time-consuming, hard on the nerves, and not too rewarding financially.

These hardships should be kept in mind when the patient first appears in your office for treatment. If the history shows that his complaint has a traumatic origin under circumstances that suggest a liability claim, you have, at that moment, your chance to escape. You can give him emergency treatment and send him elsewhere.

If, however, you undertake to treat the patient, you place yourself under a moral obligation (not to speak of a legally enforceable one) to testify later concerning his condition. If the patient has a just claim, he is then entitled to your testimony in support of it.

Frequently a doctor will tell the patient with force and candor at the very outset: "I'm glad to treat you if you wish. But it must be with the understanding that my practice doesn't permit me to go to court. I'm much too busy. I cannot testify."

Suppose the patient assents. Does that relieve the doctor of his obligation? [MORE ▶

MR. LAUREN *is a New York trial attorney and a member of the Medical Jurisprudence Committee of the New York City Bar Association.*

Well, let's consider it from the patient's viewpoint:

After a short time, it becomes apparent that he will be out of work for a long period; that he will incur large expense for treatment; that he may even suffer a permanent injury or occupational disability. He decides to sue.

Must M.D. Testify?

The doctor then offers to give him a medical certificate describing the findings, treatment, and diagnosis. But the court won't take it. It's not admissible in evidence. The rules require that the doctor must appear, be sworn, state the facts, and submit to cross-examination. Ordinarily, nothing else will do.

Nevertheless, the doctor still refuses to testify. As a practical matter, the patient is out of court. No justice for him. Why?

Because the amount of compensation he can recover depends, in great measure, upon the extent of suffering and injuries he can prove. In most such cases, effective proof rests almost entirely upon the medical testimony.

If, in desperation, the lawyer serves a subpoena upon the doctor and forces his appearance, there will be more hostility between the plaintiff and the doctor than there is between the plaintiff and the defendant.

Calling an angry doctor to the witness stand may, in fact, be legal suicide. Thus:

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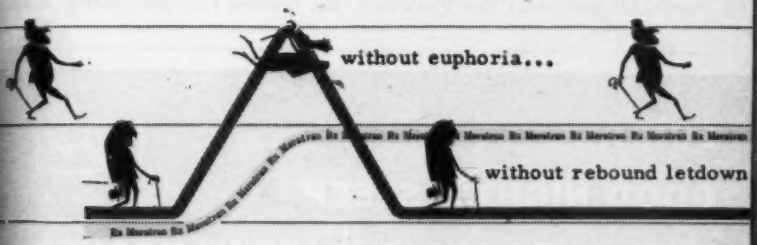
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Q. Doctor, can you form an opinion, with reasonable certainty, as to whether or not these injuries will be permanent?

A. No.

Q. Didn't you form that opinion while you were treating this patient?

OPPOSING LAWYER: I object. This is plaintiff's own witness. He has already answered that he can't form such an opinion. Plaintiff cannot impeach his own witness or lead him any further.

THE COURT: Well, it appears that the doctor may be somewhat hostile to the party that called him. I will allow the question. Answer it, Doctor.

A. Well, I did feel that the injuries would be permanent. But that's only a probability. I cannot state that opinion with any degree of certainty.

OPPOSING LAWYER: I move to strike out the medical testimony based on a "probability." The law requires "reasonable certainty."

THE COURT: Motion granted. Unless plaintiff has other evidence on that point, the jury will not be permitted to consider the question of permanence of injuries in this case.

So You Needn't

And that's only the beginning. A tactful cross-examiner, capitalizing on the doctor's hostility to the plaintiff, will have little difficulty leading the witness into devastating state-

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ments concerning other medical aspects of the case.

These may suggest that causes other than trauma are possible; that the symptoms existed before the accident; that malingering is common in this type of complaint; and so on, ad infinitum.

The Doctor Decides

In short, the doctor has it within his power, as a practical matter, to refuse to testify—or, at least, to refuse to testify cheerfully.

But almost invariably the doctor will recognize a moral obligation to testify when he is an indispensable witness in a case where he has undertaken treatment. Provided, of course, that the patient agrees to pay a reasonable fee for that service.

An attorney who subpoenas a doctor without arrangement for his compensation is almost certain to have an angry witness on his hands, with the probable results indicated. The doctor can be forced to testify, of course, without payment, as to what he observed and did. In some jurisdictions, however, the moment his *professional* opinion is called for, he has the right to refuse to answer on grounds that he is not being compensated.

Upon such a refusal, the judge will make a ruling. And the doctor is bound to answer or not, as the judge may direct.

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That's the technical rule. But as a practical matter, most lawyers recognize the justice as well as the necessity of compensating the physician for his time—regardless of whether his testimony will include a professional opinion or merely a statement of observations and treatment.

Witness Fees

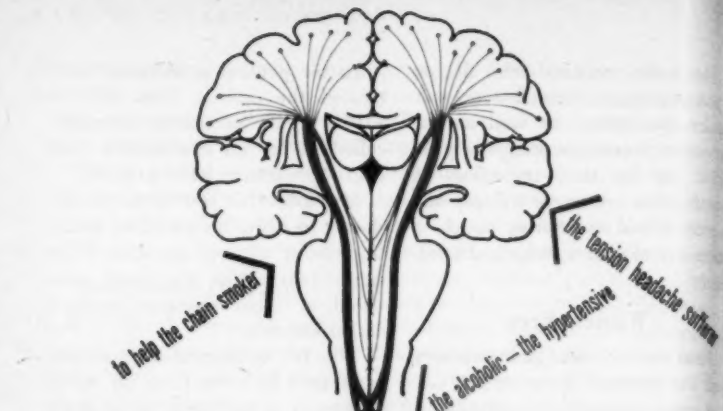
Fees vary with circumstances, and the financial status of the parties must naturally be considered. My experience is limited to a large metropolitan area where, in recent years, I have been paying fees for brief courtroom appearances as follows:

To the general practitioner who treated the patient, from $40 to $100. To the consulting specialist called in for an examination and court appearance, $100 to $150.

My custom has been to permit the doctor to name his own fee. And I approve it without question if his figure falls within the range indicated, or if circumstances justify a larger amount.

The fee arrangement is usually confirmed by letter from my office. Moreover, if the doctor so requests, his fees are paid before he takes the witness stand. I consider such a request to be perfectly reasonable, since often all parties concerned are strangers to the doctor. [MORE ▶





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If the medical issues in the case are complex, the attorney may ask for a pre-trial consultation. The doctor can be invaluable here in explaining the medical problems, suggesting lines of questioning, and finding textbook authorities and illustrations for courtroom use.

In requesting this type of conference, it is my custom to offer an additional fee—and to consider it a favor, besides.

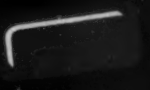
Where a special conference is not required, I find it helpful to send the doctor, a few days before trial, an outline of the questions to be put to him. Also indicated are the probable lines of cross-examination to which he may be subjected. Some doctors even ask for this outline.

The doctor may also request—and a careful attorney will arrange to get—a full transcript of the patient's hospital record (not merely a summary). This is made available to the doctor before he takes the stand. It does wonders in refreshing his recollection and in avoiding unintentional but embarrassing discrepancies between his testimony and the record of the case.

Who's on Other Side?

The doctor may even get from the attorney the names of the physicians who will testify for the other side (plus the general nature of their opinions). Usually the lawyer knows who these doctors are. He may have information as to what their position will be. [MORE ▶

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CALLED TO TESTIFY

Whenever you are asked to testify, you have a right to expect that you will be briefed along the foregoing lines. These are things that any conscientious attorney will be glad to do for you.

There are matters, however, that are entirely up to you. Most important of them is your office record. A patient's case history, full and complete from the first visit, is an invaluable asset to a medical witness. It bespeaks the doctor's care and competence. It leaves little in the hazy realm of "to the best of my recollection," or "I can't swear, but I think . . ."

Such vague answers provide a welcome springboard for a capable cross-examiner. To illustrate:

M.D. Seems Foolish

Q. You said, Doctor, that there was considerable atrophy. I believe you mentioned that the left biceps measured two inches less than the right?

A. Yes.

Q. Have you an entry to that effect on your patient's record card?

A. No, it doesn't appear there. But, to the best of my recollection, that's what it was.

Q. You made that examination three years ago?

A. Yes.

Q. How many patients have you seen since?

A. Perhaps several thousand.

Q. And you tell us you now remember specifically that this patient had

Her complaint: dysmenorrhea

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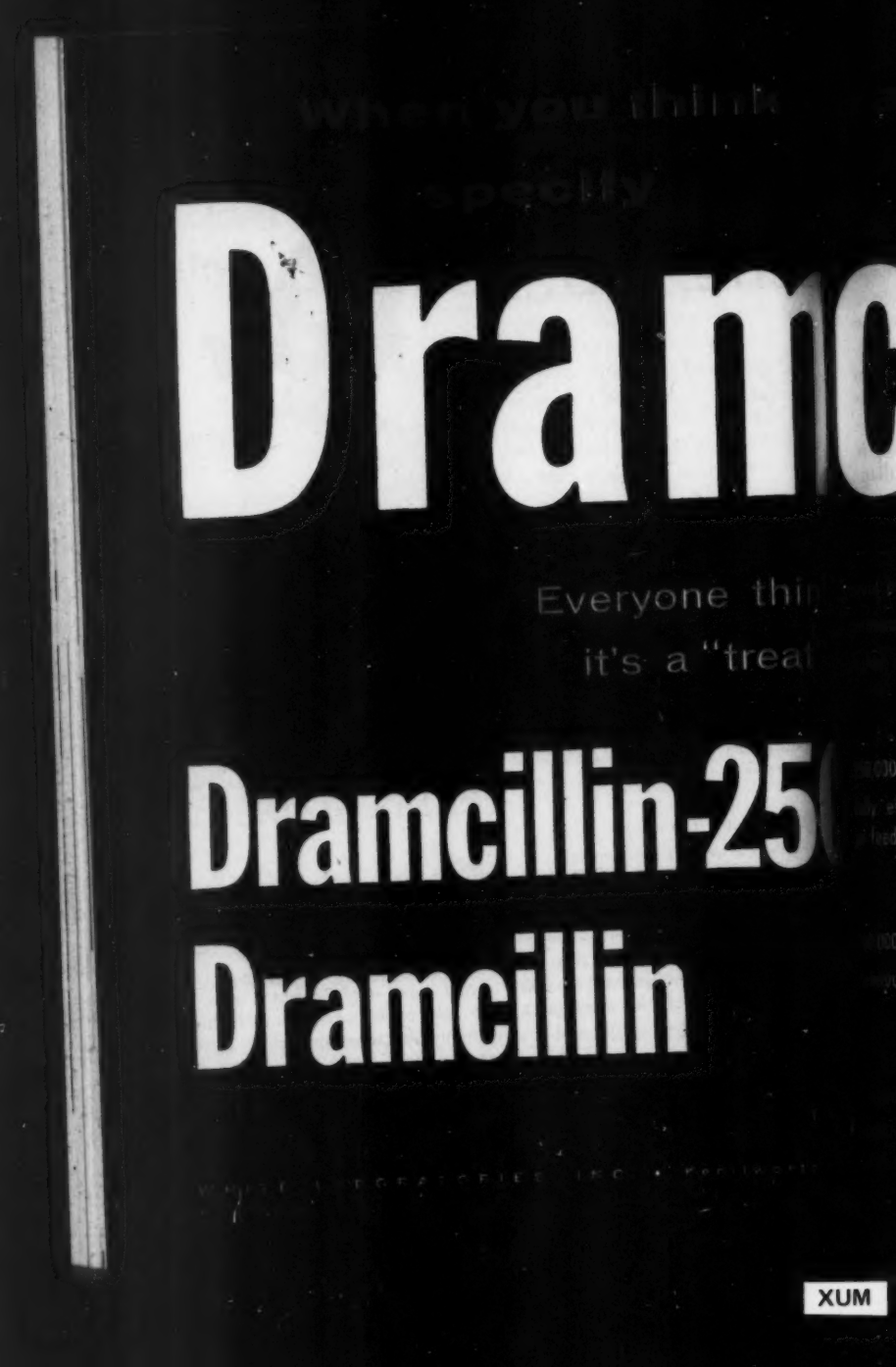
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two inches of atrophy on that day?
A. Well, I can't be sure. I seem to remember it.
Q. But you might be mistaken?
A. I suppose so.

In taking a history of the patient, there is no need to involve yourself in any controversial issue other than the medical one. If your patient tells you that "a drunken driver ran over me" and you write that on your card, you may be in for a great deal of needless examination and cross-examination at the trial.

It is sufficient for your purposes merely to record: "Struck by automobile." Thus you leave it to other witnesses to establish facts bearing upon responsibility for the accident. Your concern on that issue is merely to note that the injury is reported to be of traumatic origin.

Some caution should be exercised, too, in making reports to attorneys or insurance companies. Such reports are helpful to the lawyers in negotiating a settlement; but they are sometimes a source of trouble when you testify. Either the report should be full and complete, or you should indicate on its face that it is intended merely as a summary statement.

The reason: If your testimony is broader on tests, findings, and diagnosis than is your report, the cross-examining lawyer will make capital of it—to your discomfort. END



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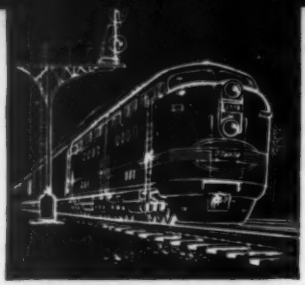
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If Doctors Get Social Security Coverage

These questions and answers show the benefits that you would receive as a self-employed physician—and also the taxes that you'd pay

By John R. Lindsey

● Self-employed doctors were left out when Congress overhauled the Social Security law last year. But they may not be left out much longer. With that prospect in mind, many of them have been asking this magazine what they can expect of Social Security if Congress votes them in.

Here are some of the answers (based, in large part, on the 1954 changes in the Social Security Act that took effect this year):

QUESTION: *If Social Security were extended to self-employed doctors, how much would I have to pay?*

ANSWER: A 3 per cent tax on your first $4,200 of net income. Beginning in 1960, the tax for the self-employed will go up to 3¾ per cent. It will rise ¾ of 1 per cent every five years until 1975. Then it will level off at 6 per cent.

QUESTION: *When would I have to pay my Social Security tax?*

ANSWER: Once a year, on April 15, along with your Federal income tax.

QUESTION: *What Social Security benefits would I get under the 1954 formula?* [MORE ▶

ANSWER: A maximum of $108.50 a month for life, upon retirement at age 65. In addition, you'd get a top of $54.30 a month for your wife, whenever *she* reached 65. (It's unlikely that most physicians would be entitled to much less than the maximum.)

QUESTION: *If I died before 65, what benefits could my wife and children count on?*

ANSWER: Probably $200 a month (the maximum) if more than one child were under 18, plus a lump sum of $255 payable at your death. If only one child were under 18, your widow would get a maximum of $162.80 a month. If she were less than 65 when the youngest child turned 18, all Social Security payments would stop, and she'd get nothing until she reached 65. Then payments would be resumed at a maximum of $81.40 a month.

You'd Have to Apply

QUESTION: *How could I be sure of receiving the Social Security benefits due me?*

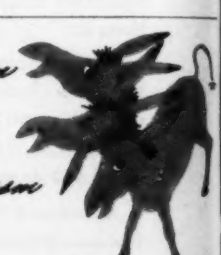
ANSWER: Only by applying for them at the Social Security office nearest you. Benefits are not paid automatically to either the insured or his survivors.

QUESTION: *Would I have to pay taxes on Social Security benefits?*

ANSWER: No. All such payments to you or your survivors would be

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nervous tension
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*Textbook of Pharmacology, (Saunders) 1952.

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tax-exempt. But the Social Security *tax* you'd pay the Government is a different matter: It could not be deducted on your Federal income tax return.

How Long You'd Pay

QUESTION: *How long would I have to pay my Social Security tax before I'd get full protection?*

ANSWER: From a year and a half up to ten years, depending on your age at the time doctors became eligible for Social Security. After ten years, you'd become what Social Security calls "fully insured for life," but this does not mean that you'd automatically get maximum benefits. (Your benefits would be figured on the basis of your average monthly earnings over the entire period you were under Social Security.)

The absolute minimum for full protection (not necessarily for maximum benefits) is eighteen months. You'd have to pay your tax at least that long to qualify for benefits of any kind. Your family could claim *some* (but not necessarily maximum) benefits if you had paid your tax for at least a year and a half of the three years just before your death.

In Social Security terms, the yardstick of eighteen months is called "six quarters of coverage." A "quarter of coverage"—the formula for deciding whether you're

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eligible for benefits—would be any period of three calendar months in which you (as a self-employed physician) earned at least $100.

Under the 1954 formula, you'd have to earn at least two "quarters of coverage" for every year you were under Social Security until you reached 65, or died.

Now, some queries about a few of the finer points:

QUESTION: *I'm 62 and netting considerably more than $10,000 a year from my practice. Assuming that I were included in Social Security before reaching 65, how long would I have to pay taxes to qualify for maximum retirement benefits?*

ANSWER: You'd pay the maximum rate of $126 a year (3 per cent of $4,200) until you reach 65—but under no circumstances for less than eighteen months, even if this meant working beyond your 65th birthday. To be sure of maximum benefits, your monthly earnings would have to average $350—the new ceiling that went into effect this year—until you became eligible for retirement benefits or died.

If You Didn't Retire

QUESTION: *I do not plan to retire from practice at 65. So what would I—or any doctor who went on earning money after 65—have to gain from Social Security?*

ANSWER: Your monthly retirement payments of up to $108.50 would begin at 72 (instead of at 75, as under the old law), no matter

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MAJOR ADVANTAGES: Swift-acting, soothing urinary analgesic. Nontoxic; local action restricted to urogenital mucosa. Compatible with sulfas and antibiotics.



FOR COMFORT
ON THE JOB . . . AND AT PLAY

EFFECTIVE—An extensive evaluation[1] of the effects of PYRIDIUM in 118 cases of pyelonephritis, cystitis, prostatitis and urethritis showed the drug relieved or abolished dysuria in 95% of the patients and reduced or eliminated nocturia in 83.7% of the cases.

WELL-TOLERATED—Specific analgesic action is confined entirely to the urogenital mucosa. PYRIDIUM may be administered concomitantly with sulfonamides or antibiotics. When so used, it provides welcome relief from painful symptoms in the interval before the antibacterials can act.

PHYSIOLOGICAL—The soothing analgesic action of PYRIDIUM helps relax irritated, tense sphincter muscles of the bladder. This relaxation minimizes the amount of residual urine.

PSYCHOLOGICAL—Prompt appearance of the characteristic orange-red color in the urine is positive assurance to the patient of PYRIDIUM's rapid access to affected areas.

SUPPLIED—in 0.1 Gm. (1½ gr.) tablets, vials of 12 and bottles of 50, 500 and 1,000.

PYRIDIUM is the registered trade-mark of Nepera Chemical Co., Inc., for its brand of phenylazo-diamino-pyridine HCl. Sharp & Dohme, Division of Merck & Co., Inc., sole distributor in the United States.

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Philadelphia 1, Pa.
DIVISION OF MERCK & CO., INC.

REFERENCE: 1. Kirwin, T. J., Lowsley, O. S., and Menning, J., *Am. J. Surg.* **62**:330-335, December 1943.

how much money you were then making. Actually, you could earn limited amounts of money and still get benefits even before becoming 72: Under the 1954 formula, you could qualify at 65 for full monthly payments in any year if you earned no more than $1,200 throughout that year.

You Could Earn More

If you worked in all months of the year and earned more than $1,200—but not more than $2,080—you would lose *some* monthly benefit checks, but not *all*. The number of checks you'd lose would depend on how much money you made and on how many months you actually worked. For example, if you earned between $2,000 and $2,080 in one year and worked in all twelve months, you'd still be entitled to one month's benefit check.

Actually, no matter how large your annual earnings, the law would allow you to draw your Social Security check for every month in which you were not actually engaged in practice.

Let's assume you earned $3,000—or even $10,000—during a period of three months. You'd lose your Social Security benefits for those three months, of course; but you could, under the law, draw your regular benefits for the other nine months. If, however, you earned the $3,000—or the $10,000—by working part-time all through the year, you wouldn't get any benefits at all.

QUESTION: *I have substantial investments in stocks, bonds, and real*

Social Security for Doctors on Salary

Salaried physicians who are already under Social Security get the same benefits as those outlined in this article for self-employed doctors; but they pay a smaller tax.

The salaried doctor now pays 2 per cent on the first $4,200 of his salary; and his employer pays a like amount. This tax, for employe and employer alike, will go up ½ of 1 per cent every five years until 1975. After that it will be 4 per cent for each.

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You'll find that each soft, soluble capsule of Am Plus curbs her appetite with 5 mg. of dextro-amphetamine... and balances her nutritional intake with 11 minerals, 8 vitamins. Dose: one capsule a half-hour before meals. In bottles of 30 and 100. Remember: for *safe* obesity control — Am Plus.

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estate. Would I lose out on Social Security benefits at 65 because of this private income?

ANSWER: No. Benefits are in no way affected by the income a person gets from property, investments, pensions, insurance, and other types of savings. Social Security is concerned only with net *earnings*, whether from self-employment or from salary.

Disability 'Freeze'

QUESTION: *If I were disabled before reaching 65, would I be eligible for Social Security benefits at that time?*

ANSWER: The law doesn't provide cash disability payments of any kind. But, as amended last year, it does protect the individual's rights and the Social Security rights of his dependents and survivors. So if you had Social Security coverage as a self-employed physician and became disabled, you could have your earnings record "frozen." Here's what this would mean:

You wouldn't have to count the time of your disability in figuring your average monthly income or the length of time you must have worked to qualify for benefits. This would make it easier for you to qualify; and it would also boost your eventual benefits.

QUESTION: *Before our marriage, my wife worked and was covered by Social Security. Assuming that I, as a self-employed doctor, were also*



schade

"Gosh, I bet you wuz surprised when you heard about it!"

Areas of Clinical Study / One of a series

ANEMIA OF PREGNANCY

Maintenance of normal blood values during pregnancy is a factor in the welfare of the mother at delivery and in preventing anemia in the infant. Improvement in the patient's vitality and emotional stability during gestation can also be achieved.

RONCOVITE, *the original, clinically proved cobalt-iron product, has introduced a wholly new concept in the prevention and treatment of anemia. It is based on the unique hemopoietic stimulation produced only by cobalt. The application of this new concept routinely in pregnancy practically insures against the development of iron-deficiency; its use has also led to marked, dramatic advances in the successful treatment of many of the anemias.*

In a recent clinical study of anemia in pregnancy, Holly[1] *reports:*

—about 80 per cent of normal patients manifest significant decreases in hematologic values during pregnancy.

—conversely, 90 per cent of pregnant women maintained hemoglobin levels of 12 Gm. per cent or over when given Roncovite (iron-cobalt therapy). No other medication tested was so successful.

—in fact, 63 per cent of these Roncovite treated patients delivered with the unusually satisfactory level of 13 Gm. per cent hemoglobin.

—Roncovite (iron-cobalt therapy) was proven to be the most effective hematinic. In fact, 57 of 58 patients (98.2%) maintained or improved their hemoglobin values.

RONCOVITE IS A SAFE DRUG.

In pregnancy—

"No toxic manifestations associated with its use have been observed."[1]

In prematures—

"None of them showed harmful effects despite the large doses..."[2]

In pharmacology—

"Histopathologic studies of rats that received cobaltous chloride ...revealed no significant degenerative changes in parenchymal organs as evidence of toxicity."[3]

SUPPLIED:

RONCOVITE TABLETS
Each enteric coated, red tablet contains:
Cobalt chloride..... 15 mg.
Ferrous sulfate exsiccated..... 0.2 Gm.

RONCOVITE-OB
Each enteric coated, red capsule-shaped tablet contains:
Cobalt chloride..... 15 mg.
Ferrous sulfate exsiccated..... 0.2 Gm.
Calcium lactate..... 0.9 Gm.
Vitamin D..... 250 units

RONCOVITE DROPS
Each 0.6 cc. (10 drops) provides:
Cobalt chloride (Cobalt 9.9 mg.)..... 40 mg.
Ferrous sulfate..... 75 mg.

DOSAGE:

One tablet after each meal and at bedtime. Children 1 year or over, 0.6 cc. (10 drops); infants less than 1 year, 0.3 cc. (5 drops) once daily diluted with water, milk, fruit or vegetable juice.

1. Holly, R. G.: Anemia in Pregnancy, Paper read at the Sixth American Congress on Obstetrics and Gynecology, Dec. 13-17, 1954, Chicago, Illinois.
2. Quilligan, J. J., Jr.: Texas State J. Med. *50:* 294 (May) 1954.
3. Hopps, H. C.; Stanley, A. J., and Shideler, A. M.: Polycythemia Induced by Cobalt, Amer. J. Clinical Path. *24:* (Dec.) 1954.

Bibliography of 192 references available on request.

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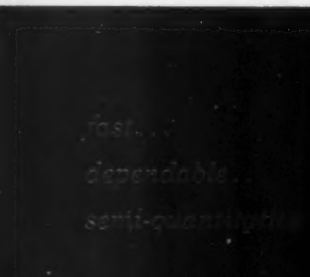
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Clay-Adams **NEW YORK 10**

covered, how would my wife's past earnings affect my retirement benefits? Would our incomes be lumped together to determine average monthly earnings?

ANSWER: Your retirement benefits would be determined only on the basis of your own income as a doctor. Your wife's earnings, past or present, would have nothing to do with it.

Your wife, however, could figure her own retirement benefits either on the basis of her own earnings or on the basis of your earnings, whichever formula would give her the larger return. As your wife, she'd be allowed up to $54.30 a month (or $81.40 as your widow) after she had reached age 65. But as a wage-earner in her own right, she might qualify for more (up to the $108.50 maximum). But she couldn't get benefits under both formulas.

On Part-Time Salary

QUESTION: *Along with my private practice, I also hold a part-time salaried job as an industrial doctor. If self-employed M.D.s were covered, could I get higher retirement benefits by paying Social Security taxes as a self-employed practitioner, in addition to the taxes already deducted from my pay checks?*

ANSWER: If your gross salary were $4,200 or more, no. If it were less, yes. For example, if your part-time salary were $3,000, you'd pay the 2 per cent tax on that, or $60. Then, to get maximum Social Security credit for higher retirement benefits, you'd pay $36 more (the 3 per cent self-employed tax on $1,200, the difference between your taxable salary and the Social Security income ceiling).

If You're a Veteran

QUESTION: *I have heard that doctors who served in the armed forces are eligible for Social Security benefits. I served thirty-six months in World War II, and have since resumed private practice. Does my military service alone qualify me for retirement benefits, or do I need additional coverage?*

ANSWER: You, like other doctor-veterans, may now be eligible for Social Security benefits on the basis of your military service alone, but only on two conditions: First, you must not already be getting a military pension from the Government (other than one from the Veterans Administration). Second, you must have reached 65—or died—before a certain date fixed by law. This date varies for each doctor-veteran according to his length of service. In your case, the date would be July 1, 1957. After that date you would need additional coverage.

Because the veterans' provisions of the Social Security Act are complicated, questions about individual problems should be addressed to the Social Security Administration, Baltimore 2, Md., or to the district office nearest you. END

XUM



Gastric Hyperacidity: etiology

People being people, environmental factors contributory to gastric hyperacidity are hard to remove, even when their role is clearly defined. But, the physician has a sure, simple—even pleasant—way of relieving the acid distress caused by:

- dietary indiscretion
- nervous tension
- emotional stress
- food intolerances
- excessive smoking
- alcoholic beverages

Gelusil promptly and effectively controls the excessive gastric acidity of "heartburn" and chronic indigestion. And it affords equally rapid relief in peptic ulcer. Sustained action is assured by combining magnesium trisilicate with the specially prepared aluminum hydroxide gel.

Free from constipation: Gelusil's aluminum hydroxide component is specially prepared: the concentration of aluminum ions is accordingly low; hence the formation of astringent—and constipating—aluminum chloride is minimal.

Free from acid rebound: Unlike soluble alkalies, Gelusil does not over-neutralize or alkalinize. It maintains the gastric pH in a mildly acid range—that of maximum physiologic functioning.

Dosage—2 tablets or 2 teaspoonfuls two hours after eating or when symptoms are pronounced. Each tablet or teaspoonful provides: 7½ gr. magnesium trisilicate and 4 gr. aluminum hydroxide gel.

Available—Gelusil Tablets in packages of 50, 100, 1000 and 5000. Gelusil Liquid in bottles of 6 and 12 fluidounces.

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Hoover Says, 'Cut Out Fat In U.S. Health Services'

Urging an end to waste in Federal health spending, the Hoover Commission comes up with twenty-nine specific suggestions (some highly controversial) for getting the job done

By Paul Lowell

● One month ago, the new Hoover Commission reported to Congress that it had found "chaos," "duplication," and "huge waste" in the Government medical services. The Commission painted this picture of sprawling Federal medicine:

¶ The Government "has undertaken specific responsibility for all or part of the medical care of about 30 million" Americans.

¶ "Twenty-six Federal departments or agencies engage in . . . health functions . . . Within these agencies, sixty-six administrative units have health functions."

¶ "The Federal Government employs about 10 per cent of all active physicians, 9 per cent of the active dentists, and 6 per cent of the active graduate nurses."

¶ In the current fiscal year alone, the Government is spending $4 billion on its health programs (half of this on disability payments); and even more is being budgeted for the coming year.

What can be done about this? Plenty, says the Commission. It has put together a list of twenty-nine recommendations to effect coordination between various Gov-

ernment departments, to eliminate outmoded and overlapping services, and to develop certain new services. (The full series of recommendations appears at the end of this article.)

Doctors Wrote Report

Since the Hoover Commission is a lay body, it based its recommendations on the report of a special Medical Services Task Force made up mainly of eminent physicians—among them Theodore Klumpp, who served as chairman; Walter B. Martin, President of the A.M.A.; Edwin L. Crosby, director of the American Hospital Association; and Paul R. Hawley, director of the American College of Surgeons.

Following task force suggestions, the Commission recommended the establishment of a Federal Council of Health to oversee Government medical activities; it called for voluntary health insurance for Federal employes; it urged an end to free medical service for merchant seamen.

But Commission thinking didn't dovetail 100 per cent with task force thinking. Some important areas where differences turned up:

Differences of Opinion

1. *The doctor draft.* The task force suggested that the draft be allowed to expire this June 30. The Commission, on the other hand,

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Dicalcium Phosphate 290 mg.
Calcium Gluconate 190 mg.
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✔ Perhaps it's because you like the low patient cost.

✔ Perhaps it's because patient acceptance assures that your medication is actually taken.

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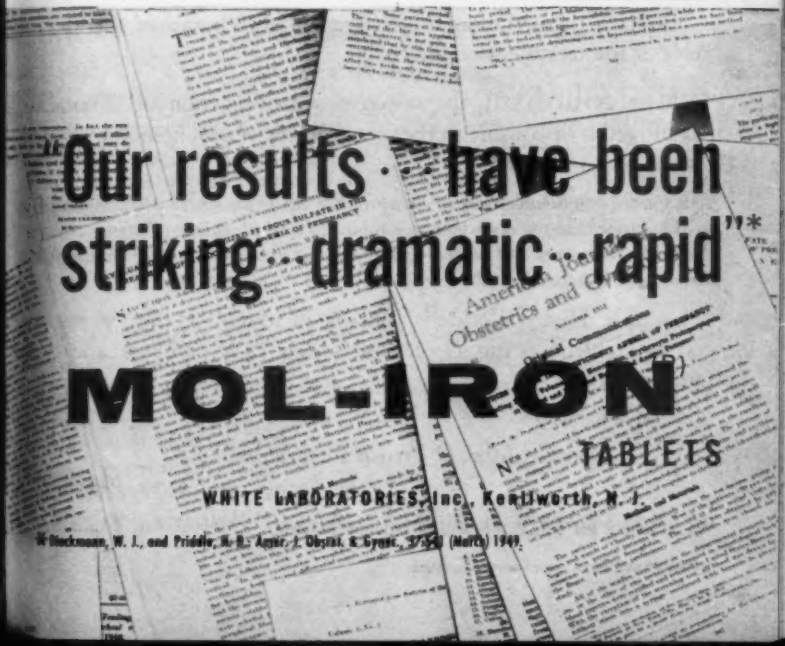
merely called for a review of the draft situation "to effect maximum utilization of medical personnel."

2. *Veterans Administration hospitals.* The task force proposed that the V.A. shut down nineteen hospitals which "have such a small bed capacity, are so poorly located, or have such a low rate of bed utilization that their continued operation is uneconomic and ineffective." The Commission didn't wholeheartedly endorse this plan. It simply recommended that the V.A. consider the idea.

3. *Care of non-service-connected cases.* The task force said that free V.A. treatment of such cases should be given only where "the need . . . is demonstrated within three years from the date of discharge [and in cases where] the veteran is financially unable to pay." The Commission took a somewhat softer view; it recommended that the V.A. tighten its screening of veterans who plead poverty.

4. *Public Health Service hospitals.* The task force made no specific proposal concerning these sixteen installations. But, surprisingly, the Commission recommended that all but four of the hospitals be disbanded.

What are the prospects for turning these and other Commission recommendations into law? As this issue went to press, there was evidence that the new Hoover report





The expanding scope of a versatile new drug

THORAZINE*

'Thorazine' has achieved dramatic results in many major clinical applications:

In **nausea and vomiting,** 'Thorazine' has become established as specific for the prompt control of severe symptoms.

In **mental and emotional disturbances,** 'Thorazine' has rapidly become a standard therapy, often relieving conditions heretofore refractory to any pharmacological measures.

In the treatment of **pain,** 'Thorazine' has assumed an important role as a potentiator of analgesics, making it possible to use much smaller doses of narcotics or less potent narcotics.

In **hiccups,** the rapid effectiveness of 'Thorazine' therapy has made it the treatment of choice.

In **alcoholism,** the selective sedative action of 'Thorazine' has proved it invaluable in the management of psychomotor agitation and delirium tremens.

It is indeed remarkable that so many of the early pharmacologic conjectures as to 'Thorazine' have so soon become established clinical realities. This is, of course, due to the widespread and intense medical interest in the drug, on which new articles are constantly appearing.

'Thorazine' Hydrochloride is available in 10 mg., 25 mg., 50 mg. and 100 mg. tablets; 25 mg. (1 cc.) and 50 mg. (2 cc.) ampuls; and syrup (10 mg./5 cc.).

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*Trademark for S.K.F.'s brand of chlorpromazine.

would face tough sledding in Congress, as did the first Hoover report six years ago. An immediate indication of trouble ahead: Representative Chet Holifield (D., Calif.), a Commission member, blasted the majority report and turned in one of his own.

Before the Government tries to cut back on its medical services, said Holifield, it should bear in mind that many families are "unable to meet the present high costs of medical care. When the Government faces up to this problem and takes the initiative in devising an adequate medical insurance system for the whole population, perhaps it will be relieved in substantial part of the heavy demands for direct medical services and large expenditures cited in [the majority] report."

It seemed clear last month that Holifield's objections would be echoed by many other Congressmen. It seemed likely, too, that veterans' organizations would dig in for an all-out battle to prevent any curtailment of the V.A. hospital program.

Whatever the fate of the Hoover report on reorganization of the Federal medical services, it's bound to be a major Washington conversation piece for months to come. To give you a more detailed picture of the report, here (quoted) are the reasoning behind it and the recommendations from it:

Hoover Reasoning

The lack of coordination and waste [among Federal health services] are evident in the hospital construction programs of both the Veterans Administration and the Department of Defense.

Since 1952, the number of unused beds in military and veterans' hospitals has increased from 60,000 to about 77,000. Construction now in progress is likely to add another 10,000 beds.

Some beds must be kept in reserve in Federal hospitals. Yet . . . the total original cost of the unused beds probably exceeds $500 million.

Nor is the waste limited to money. The technical personnel required to operate these partly unused facilities is a drain on the technical personnel much needed by the civilian population.

It may be argued that this excessive Government hospital construction is needed against war emergency. An answer can well be that had these funds been used to relieve the civilian situation, the civilian hospitals would equally be available for war emergency.

• • •

Reduction of the length of patient

stay in Federal hospitals would decrease the need for Federal hospital capacity. Our . . . task force has this to say concerning lengths of stay in military hospitals:

"Military personnel on active duty receive relatively large amounts of hospital service, an average of eight days a year (exclusive of battle casualties), as compared to one day a year in general hospitals for the U.S. population. There are good reasons in the mode of military living which require more than average hospitalization. But this very sharp difference in the amount of care received points up a finding not only of our own studies, but of countless studies in the past—that patients tend to linger in military hospitals. Time passes while the patient is 'worked up,' while he convalesces, while a board passes on the ultimate disposition of his case . . . In general, the amount of hospitalization given to military personnel seems excessive in terms of good medical care. The stay of many cases is too long and is influenced strongly by administrative considerations."

• • •

There is [now] no one point where Federal medical policies and activities can be reviewed in order to further coordination, eliminate duplication, and develop over-all policies. There should be an agency within

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the Executive Branch charged with these responsibilities. There is at present, in the Office of Defense Mobilization, the Health Resources Advisory Committee which serves also as Advisory Committee to the Selective Service System. It is proposed that these functions should be absorbed by a new Federal Advisory Council of Health.

The functions of such a proposed Advisory Council might include [the following]:

¶ To make recommendations and continuous evaluation of policies and programs relating to Federal medical care and national health.

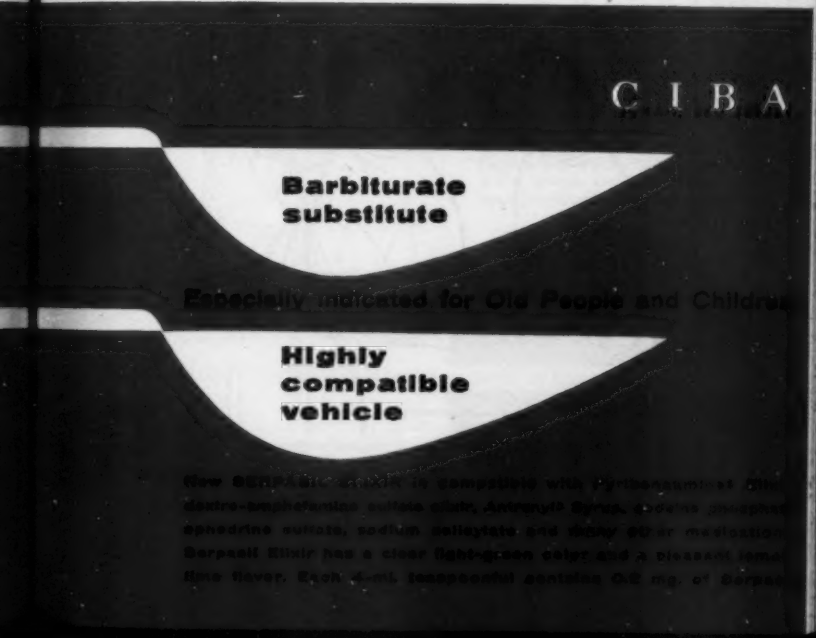
¶ To advise on measures for assuring adequate health manpower and hospital facilities for the nation's health.

¶ To review proposals and programs, and advise the President on all hospital construction involving Federal funds including Federal grants.

Such a council would be the beginning of the end of the present chaos.

• • •

In the original 1946 proposals for unification of the Armed Services, the unification of their Medical Services was held out as one of the advantages . . . This has also been recommended by various independent investigations including the first Hoover Commission, but has been



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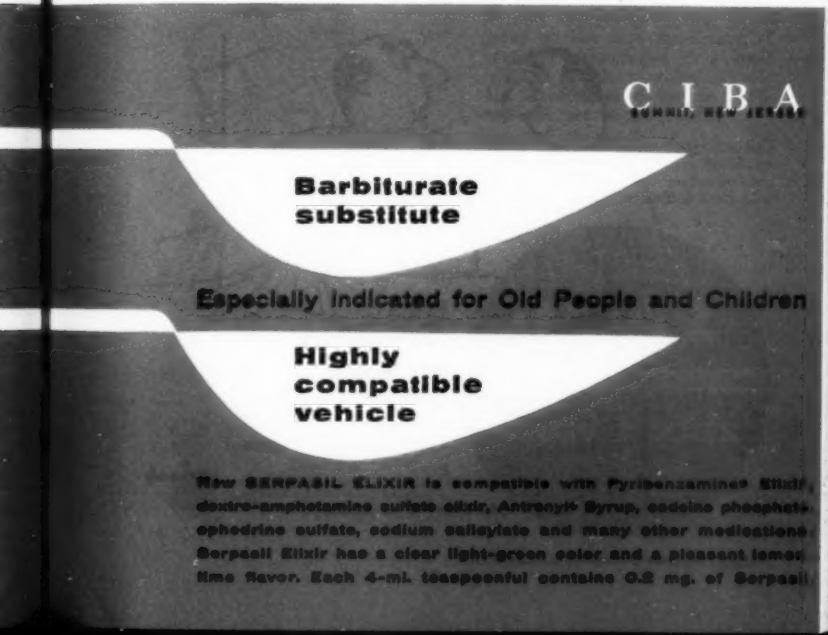
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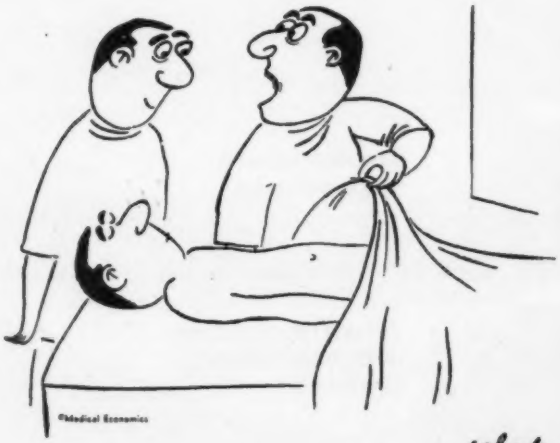
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steadily opposed by the Armed Services.

The task force of this Commission confirms the report of the first Hoover Commission, stating: "There is duplication and even competition in the provision of services by the Army, Navy, and Air Force. There are too many small hospitals and infirmaries within easy reach of large facilities which have empty beds and not overburdened staffs. Medical specialists are too scattered—many of them are in hospitals which cannot make full use of their valuable training or skills."

There is a lack of coordination between the health activities of the three services, much of which could be remedied by strengthening the office of the Assistant Secretary of Defense (Health and Medical). Regionalization of military medical services we find to be a necessity.

Ample, if not indeed extravagantly abundant facilities exist. In the absence of unification, regionalization can offer the best solution. A regional pattern in which one Service has been given responsibility for the care of patients of all Services in certain overseas areas has proven successful. Responsibility for medical care for the three Services could be assigned to the Service with the major interest in each region of the United States in such a way that the nationwide proportion of the total



"He owns a pawnshop."

PEDIATRICS BULLETIN

Prepared In The Interests Of The Profession By The Pediatrics Consultant Staff Of H. J. Heinz Company

PSEUDO PHOTOPHOBIA IN CHILDREN

PHOTOPHOBIA, like many other symptoms, may suggest something quite different in children than in adults, and in books on differential diagnosis little mention of the fact is made that photophobia may be simulated in children by the onset of diplopia.

● **When double vision** is first experienced by a child who is old enough to have become accustomed to consensual vision, but too young to describe his sensations, a type of pseudo photophobia may result which is often not noticed or is misinterpreted.



● **With a fairly sudden** onset of double vision, the confused child is apt to avoid visual experiences. He may peek out between half closed lids, turn his head away from light, bury it in a pillow, or cover his eyes with his arms in ways which look very much like the ordinary photophobia, even though evidence of conjunctivitis is absent.

● **The seriousness** of the acute development of diplopia is obviously great, and the physician is indeed shrewd who recognizes this possibility at the first appearance of apparent photophobia in a small child so that the neurological problem involved, which may be a difficult one, can be fairly faced.

NOTE: These bulletins are designed to help disseminate modern pediatrics knowledge to the general medical profession and appear periodically in Medical Economics.

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responsibility for medical care now assumed by each of the three departments would not be materially altered. As a result, many small facilities could be disposed of.

[For example] task force surveys indicated that in the New York, Norfolk, and Boston areas, the Navy, which now carries major responsibility, could well carry the whole military responsibility. In the San Antonio area the Army or Air Force would be the logical department. The San Francisco area is in effect two distinct areas; here the Army could well be responsible in the San Francisco area itself and its environs, and the Navy in the East Bay area.

In the five areas surveyed, nine military hospitals and nine infirmaries were obviously marginal to the needs of Federal Government beneficiaries. In March, 1954, these eighteen facilities had 1,200 patients. Savings which could be achieved by their closing are estimated at between $5 million and $10 million annually.

• • •

At the present time, of the 21 million living veterans, about 17.5 million are potentially eligible for hospitalization for non-service-connected care, subject to the limitation imposed of declared inability to pay and the availability of beds. The 40,000 beds existing in Veterans Administration hospitals in the year 1933 would have been sufficient to accommodate the highest average daily number of service-connected patients in any year from 1933 to date—including the service-connected cases from World War II and Korea. Yet, since 1933 the number of operating beds in Veterans Administration hospitals has grown from 40,000 to 118,000 (more than 128,000 constructed beds), representing estimated expenditures of more than $1 billion for beds not required for care of service-connected disabilities.

'Firm Legal Basis'

In 1954 the non-service-connected cases occupied, on an average day, 65,000 out of the total of 109,000 occupied beds in Veterans Administration hospitals. The cost for the hospital and medical care of these non-service-connected cases amounts to about $500 million annually.

The outstanding need of the Veterans Administration is a firm legal basis for determination of eligibility for medical care of veterans with non-service-connected disabilities.

• • •

Upon implementation of recommendations . . . for ending Federally provided care for merchant seamen, and for further relieving the patient load in the Public Health Service hospitals, only a small group of patients in the existing Public Health Service general hospitals will remain, notwithstanding the impending transfer of the hospitals and clinics of the Bureau of Indian Affairs in the Department of Interior,

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PUTS A LOAD ON HIS HEART !

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to the Department of Health, Education, and Welfare in July, 1955.

Therefore, with these arrangements, it should be possible to close twelve Public Health Service hospitals, with 3,600 beds and an annual operating cost of $19 million.

• • •

The Federal Government is now the largest employer in the free world. Our task force has investigated and given much thought to the application of health insurance to Federal medical beneficiaries, and it recommends that the Government should organize such a service upon the basis of the already existing voluntary and contributory plans.

Such plans would not apply to groups for whom the Government's responsibility for complete medical care is reasonably justified—for example: to the service-connected disabilities of veterans, to the men and women in active military duty, or to their dependents in overseas areas.

Hoover Recommendations

The Hoover Commission's report contains the following twenty-nine proposals for revising Federal medical services:

1 That the President appoint a Federal Advisory Council of Health, to be comprised of members of the medical professions together with lay members of distinguished records in fields other than the medical profession . . .

2 That the medical and hospital services of the three Armed Services be modified into a much more closely coordinated pattern which will provide that:

a. Military medical and hospital services within Continental United States be coordinated by assigning to a single military Department the responsibility under the direction of the Secretary of Defense for supervisory hospital service in a defined geographic region and that this concept be furthered wherever practicable in extra-continental areas;

b. Patients of all military Departments requiring highly specialized medical care be concentrated into special hospitals, each of which will serve the three Departments;

c. The Secretary of Defense be given authority to strengthen, consolidate, modify and reallocate medical area care responsibilities of the three Departments in line with recommendations (a) and (b) above; and that:

d. Each of the three military Departments maintain a medical center, the components of which should be a hospital and a center for education of military medical person-

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nel occupied with medical problems identified with the primary mission of the Department.

3 That the Secretary of Defense, with the assistance of the Federal Advisory Council of Health, develop recommendations for revision of the Selective Service Act to effect maximum utilization of medical personnel.

4 That the Secretary of Defense strengthen the Armed Services training program for interns and residents, for other physicians and dentists on active duty, and for reserve officers not on active duty.

This program should be planned and directed from the medical center of each Service . . .

5 That the Administrator of the Veterans Administration consider the recommendations made by the task force as to closing of certain hospitals and obtain the advice of the Advisory Council; that all hospitals determined to be surplus be closed immediately.

6 a. That all present outstanding authorizations and appropriations for construction of additional Veterans' General Hospitals be rescinded except for those now under construction or under contract.

b. That the Veterans Administra-

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tion dispose of, by sale or otherwise, any hospital which in its judgment can no longer be operated effectively and economically; and that the proposed Federal Advisory Council of Health on behalf of the President review the manner in which the hospital facilities of the Veterans Administration are being used and make recommendations for disposal or more economic utilization of the hospital plants.

7 That the statement of a veteran of his inability to pay for hospitalization for non-service-connected disabilities be subject to verification; and that the Veterans Administration be authorized to collect in case such a statement is not substantiated.

8 That veterans having service-connected disabilities but making application for treatment of non-service-connected disabilities be required to sign a statement of inability to pay.

9 That the veteran assume a liability to pay for care of his non-service-connected disability if he can do so at some reasonable time in the future. Such a debt should be without interest . . .

10 That outpatient care . . . be furnished to indigent veterans with

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non-service-connected disabilities (This does not include neuropsychiatric cases prior to hospitalization.) Such patients should also assume a liability to pay for their care if they can do so at some reasonable time in the future.

11 That the Veterans Administration emphasize its program of medical care and rehabilitation services for the aging veteran eligible for care, in order to reduce the number of chronic bed cases.

12 That the medical care functions of Veterans Administration regional offices be consolidated with and, where practicable, physically located within nearby Veterans Administration hospitals.

13 a. That responsibility and authority to establish and maintain medical criteria for disability be transferred from the Compensation and Pension Branch of the Department of Veterans Benefits, to the Department of Medicine and Surgery.

b. That [this] Department develop and maintain a mechanism for review of disability allowances ...

14 That all laws relating to veterans or veterans benefits, and in particular to medical treatment and domiciliary care benefits, be consolidated and enacted into a single

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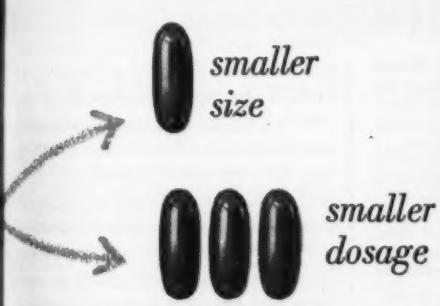
all-inclusive, comprehensive code; and that all of the existing rules, regulations and executive orders relating to veterans and to veterans benefits be brought together in one volume.

15 That the provision of hospital and clinical service to American merchant seamen by the Federal Government be ended.

16 a. That pending the establishment of voluntary contributory health insurance plans for dependents, the hospital and medical care of the Coast and Geodetic Survey, the Coast Guard and the Public Health Service personnel be provided for by military medical services at their nearest facilities, and that their dependents be similarly cared for on a reimbursable basis between the agencies.

b. That Federal Government employes receive care for job-connected illness in non-Federal hospitals at the expense of the Bureau of Employes Compensation in the Department of Labor.

17 That except for mental, drug addict, tuberculosis hospitals, the leprosarium and also facilities for the care of Indians, and the Freedmen's Hospital, the Public Health Service should close all of its general hospitals and all of its clinics, except



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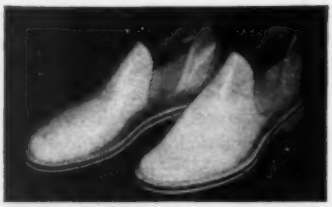
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research activities, such as those conducted by the National Institutes of Health and those clinics necessary for (a) physical examination of Federal civilian employes, and (b) examination of foreign nationals entering the United States . . .

18 That the Secretary of the Department of Health, Education, and Welfare reconsider the whole question of the use of specific Federal grants to the States for health purposes, particularly in relation to the inflexibility of the system currently in operation.

19 That the President establish a joint committee representing the Department of Health, Education and Welfare, the Department of Agriculture, and the Bureau of the Budget, with the advice of the Federal Advisory Council of Health, to make a detailed examination of the policies, programs and operations of the Food and Drug Administration and the Agricultural Research Service in the Department of Agriculture, with a view of eliminating those activities that are no longer necessary and of eliminating conflicts and overlaps existing between Departments.

20 That the Executive Branch develop a voluntary contributory program of medical and hospitalization insurance, to be conducted through a pool of private health insurance agencies, for all the civilian



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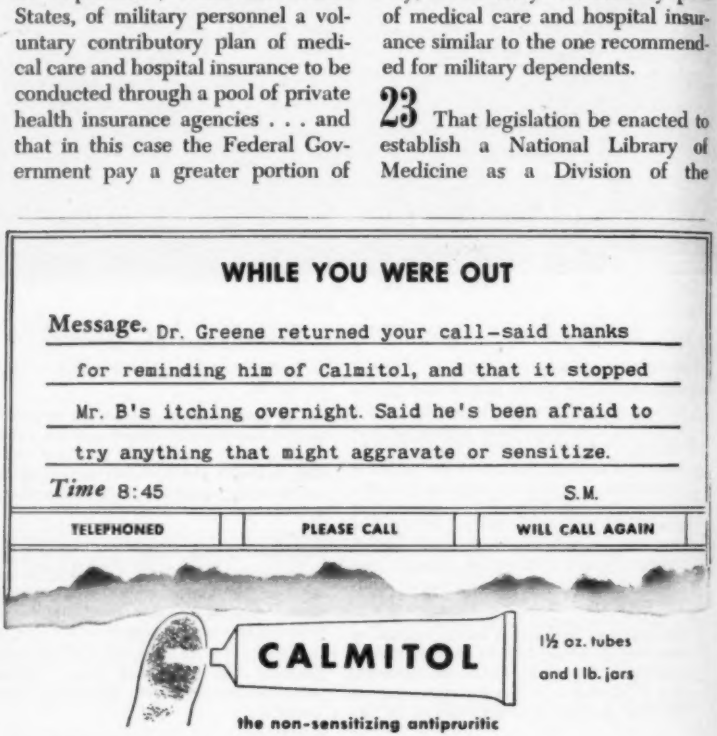
XUM

employees of the Federal Government, on a prepayment basis and using payroll deductions. The Federal Government should pay a portion of the cost. This program should contain a provision for convertibility to family coverage on termination of Federal employment.

21 That the Government develop for dependents, within the United States, of military personnel a voluntary contributory plan of medical care and hospital insurance to be conducted through a pool of private health insurance agencies . . . and that in this case the Federal Government pay a greater portion of the cost than might be determined by the Congress for civilian employees. Such insurance for dependents would be convertible to family coverage on completion of military service . . .

22 That the Government develop for dependents of uniformed personnel of the Public Health Service, the Coast Guard and Geodetic Survey, a voluntary contributory plan of medical care and hospital insurance similar to the one recommended for military dependents.

23 That legislation be enacted to establish a National Library of Medicine as a Division of the



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Smithsonian Institution . . . and that a board of trustees be responsible for directing the policy of the National Library of Medicine. The medical collections, staff and activities of the Armed Forces Medical Library should be transferred to these trustees. Housing and a budget adequate for the National Library of Medicine should be provided.

24 That the proposed Federal Advisory Council of Health make recommendations to improve preventive health services, including those rendered in connection with medical care of Federal beneficiaries, in the interests of both health conservation and economy.

25 a. That the proposed Federal Advisory Council of Health be given responsibility for reviewing the health research programs of the Federal Government and for making appropriate recommendations to the President; and

b. That the present system of project grants to institutions or agencies for research pertinent to health be . . . gradually replaced by a system of grants not confined to a specific year (i.e., "no-year" grants), these grants to be made in accordance with an approved overall plan for health research submitted by each institution or agency.

26 That the Federal Government in making plans for assignment of responsibilities during and immediately following any possible attack on the continental United States also include in its consideration of the problem the question of appropriate delegations of operational authority for directing medical care.

27 That the proposed Federal Advisory Council of Health examine means of establishing cooperative planning among Federal agencies providing psychiatric care; that the military services and the Veterans Administration give greater emphasis to preventive psychiatric services; and that the Federal Government, through the medium of the Public Health Service, encourage more research and more training of psychiatrists and workers in allied fields.

28 That the President's advisor on personnel review the personnel systems of the several Federal agencies using health personnel and consult with the proposed Federal Advisory Council of Health with a view to making them more uniform; and that he give consideration to greater use of cross-agency assignment.

29 That in the event the proposed Federal Advisory Council of Health is not created, the President assign the functions of review and advice proposed for it to other agencies. END

XUM

Is Good News Coming About Blood Banks?

After years of confusion, doctors seem about to benefit from a program that will coordinate blood banking at the national level without interfering with local rights

By Wallace Croatman

• In the long controversy over blood banking, one obvious point has often been overlooked. It is simply this: The doctor's only real concern in this field is clinical. He doesn't want to get bogged down in administrative and jurisdictional squabbles; he wants to be sure that he has all the primary types of blood constantly available; and he wants to feel confident that he is working with a product of the highest possible quality.

Admittedly, giant strides have been made in blood collection, processing, and distribution. Twenty years ago, only about one out of every 175 hospitalized patients received a transfusion. The current ratio is about one out of every nine.

Even so, some medical men are convinced that progress has been less rapid than it should have been. Why? Because of the open feuding that has gone on for years among the Red Cross, the American Association of Blood Banks, and other interested groups.

Fortunately, a good deal of the bitterness seems to be subsiding. At least, that's the main conclusion to come out of a recent inquiry made by this magazine. Some

fifty authorities were asked for their candid opinions about the future of blood banking. Most of them said they think the chance of honest cooperation among the groups concerned is greater today than at any time in the past.

How will *your* practice be affected by future developments in blood banking? Here, judging from what the authorities predict, are some of the main trends to look for:

1. Expect major organizations involved to form a workable National Blood Foundation—possibly before this year is out.

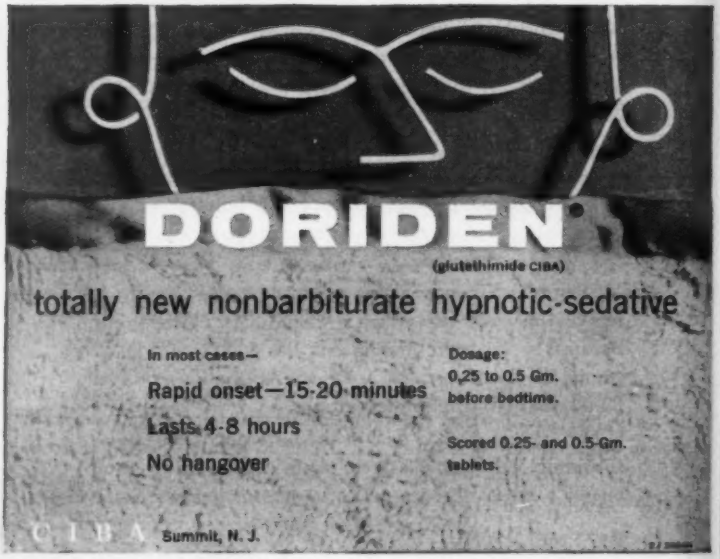
Everyone, it seems, is on record as favoring a national coordinating body in which all interested groups will have a voice. And just about everyone feels there hasn't been enough cooperation up to this point.

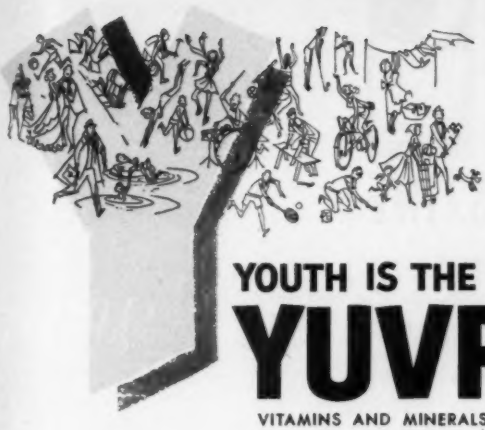
Kiss and Make Up

Significantly, leaders of both the American National Red Cross and the American Association of Blood Banks—bitter rivals in the past—have made strikingly similar statements on the subject.

Says Dr. David N. W. Grant, medical director of the Red Cross: "In my opinion, the National Blood Foundation will be created during the year 1955 . . . Such an organization is essential for coordinating our blood resources, particularly in the event of a national emergency.

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Calcium (as $CaHPO_4$)	69 mg.
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There is no doubt in my mind that the foundation will work, [though] it will require the cooperation of all agencies involved."

Says Dr. Merlin L. Trumbull, president of the American Association of Blood Banks: "The prospects [for making the new foundation work] are good, providing all of the agencies sponsoring the plan are willing to recognize the interests of each other and permit compromises to be made by all organizations."

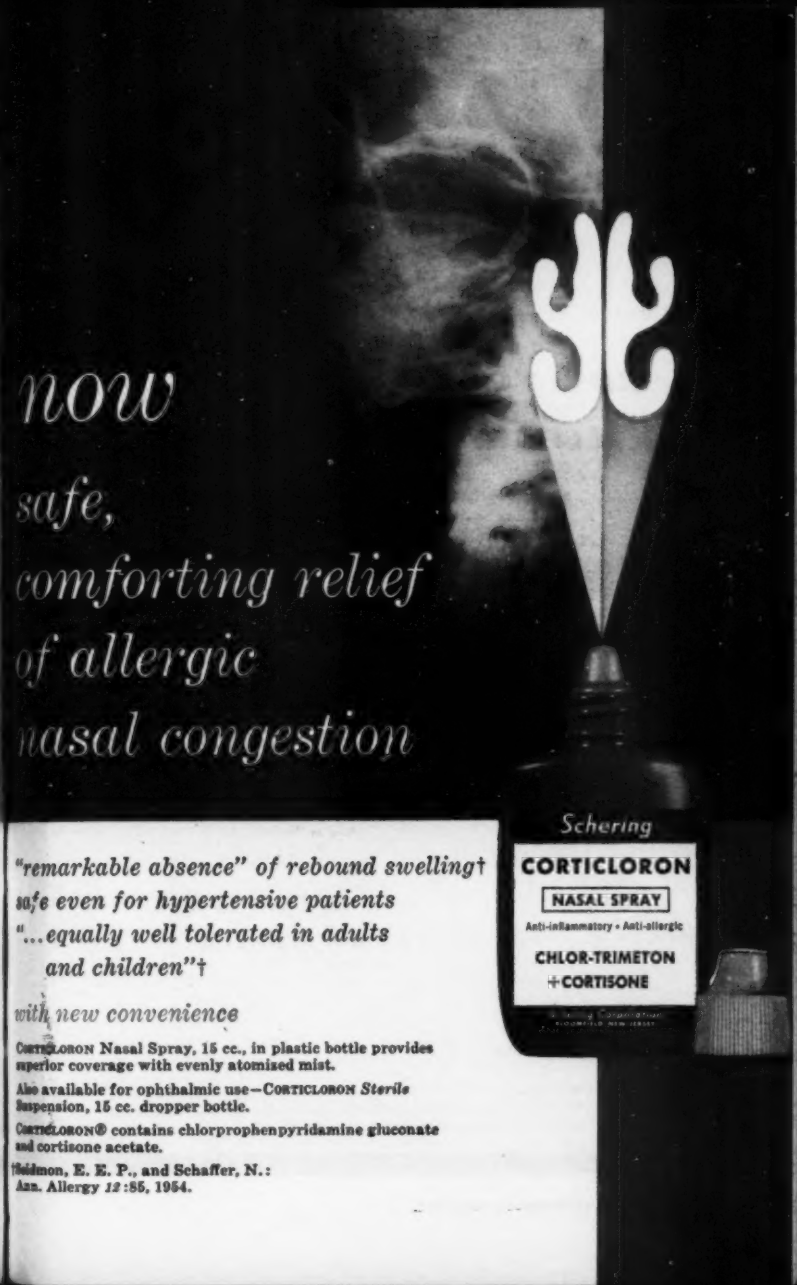
If the proposed foundation *is* a success, the A.M.A. will be in for a fair share of the credit. Up to a few years ago, the A.M.A. followed what many medical men considered an ineffectual course in regard to the blood-banking problem. Yet it was largely through A.M.A. efforts last year that five organizations—the American Hospital Association, the American Association of Blood Banks, the American Society of Clinical Pathologists, the American National Red Cross and the A.M.A.—finally worked out plans for a coordinated program.

As matters stand now, the National Blood Foundation will focus on three goals:

¶ Free exchange of blood among all member banks (on a unit-for-unit basis).

¶ Elimination of "profiteering." (Service charges to patients will be based on actual costs of collecting, processing, and distributing blood.)

¶ A system of accreditation and inspection. (All member banks will



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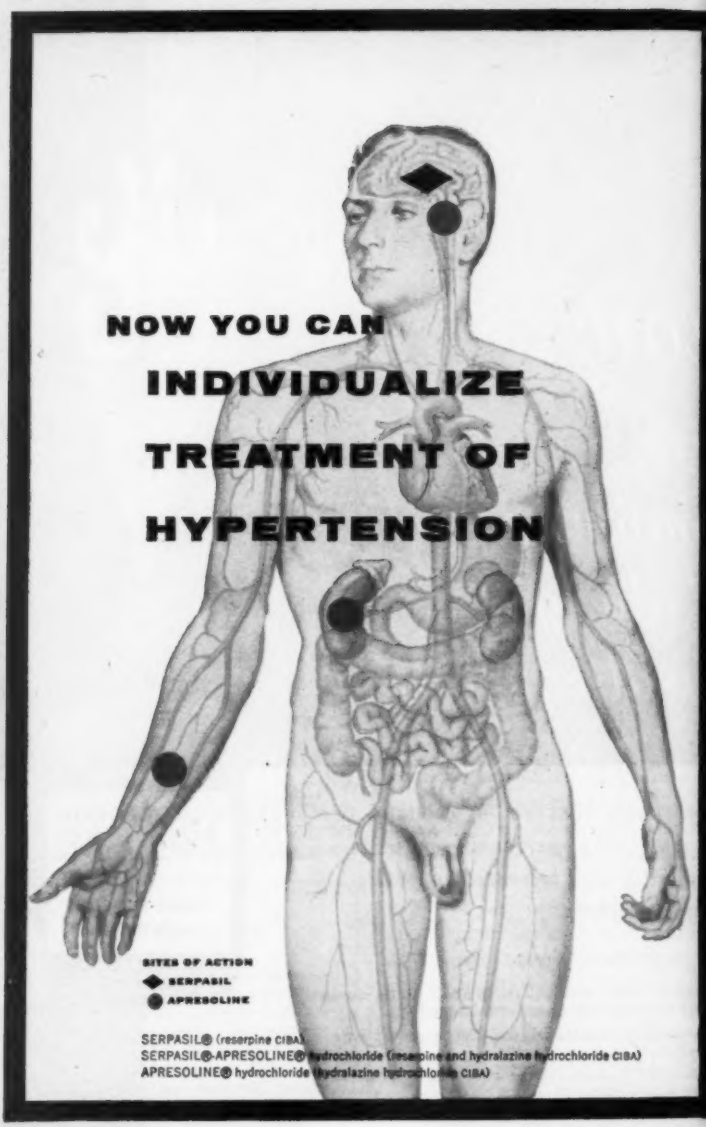
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†Feldmon, E. E. P., and Schaffer, N.: Ann. Allergy *12*:85, 1954.

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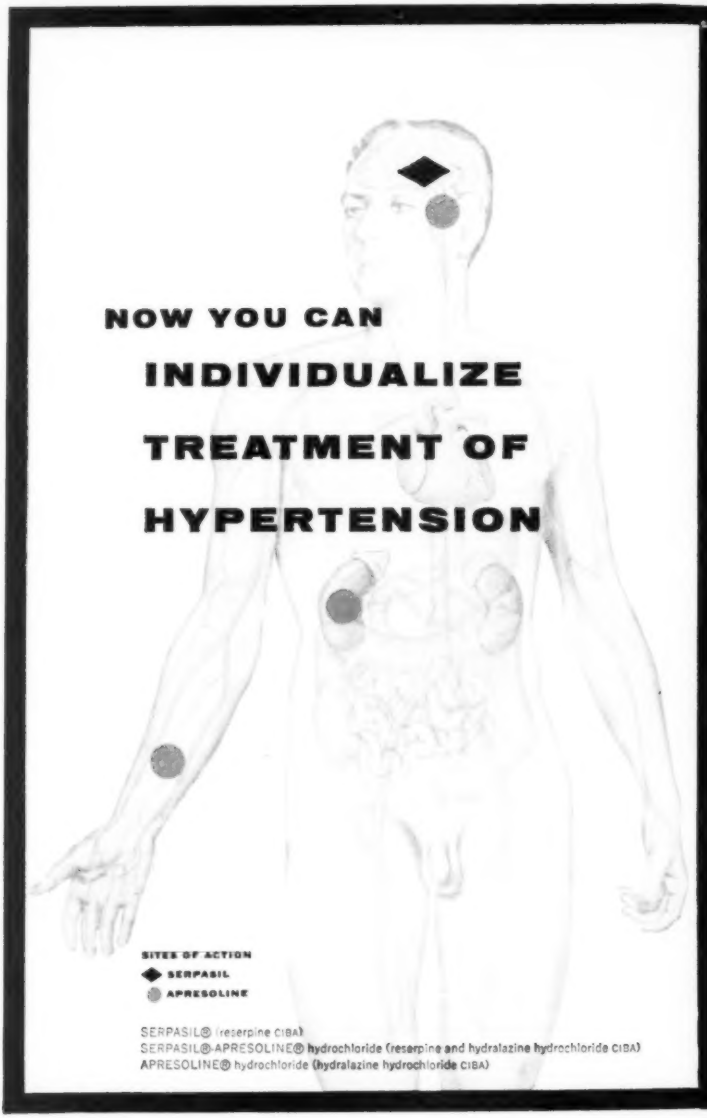
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have to meet standards fixed by the National Institutes of Health.)

Having agreed on these aims, the five groups must still get together on such practical matters as where the foundation will have its headquarters, who its administrators will be, and how it will be financed.

This last is the main problem now outstanding; but it's far from insurmountable: The foundation will simply coordinate the work of existing blood banks. It won't have to run any banks of its own. At first, operating funds will probably come largely from the five sponsoring groups. Eventually, most of the costs will probably be assumed by the local banks benefiting from the program.

Help for Research

The foundation promises to be a powerful assurance that safe, plentiful supplies of all types of blood will be made available in all parts of the country. Yet it will most likely help physicians in other ways as well.

For one thing, it should serve as a convenient medium for exchanging research information. It should also help spike much of the loose talk about physicians' supposed profits from blood. (A flagrant example of this type of charge was the Collier's article "Should Blood Banks Make Money?" See MEDICAL ECONOMICS, December, 1954.)

"Physicians must realize," says one M.D., "that blood has had a peculiar emotional connotation to people ever since Biblical times. We can't even afford to let people *think* we're making a profit on the sale of blood, let alone actually make one. That's why it is so important to have organizations outside medicine taking part in any plan to distribute blood."

2. Expect the Red Cross to start curtailing its blood program nationally (but not locally).

The end of the Korean fighting brought a sharp cut in the Government's use of Red Cross blood. It may also have contributed to the agency's fund-raising slump. At any rate, last fall, Red Cross' Washington headquarters drew up a long-range plan aimed at shifting the financial burden of blood procurement to its local chapters. Two years from now, the national organization will probably be furnishing only about 25 per cent of the cost of running the regional programs.

More Autonomy

One important result of this policy may be to make the individual Red Cross centers increasingly dependent on the support of other interested groups—like medical societies. From the standpoint of community-wide cooperation, then, the new policy should be all to the good.

3. Expect most nonprofit blood banks—even some Red Cross banks—to make patients responsible for replacing blood they get. [MORE ▶

XUM

Now you can do more

Stress SF Fortified

The availability of such anti-infectives as Terramycin, Tetracyn and penicillin has not altered the wise admonition to "treat the patient as well as the disease." As the National Research Council[1] has emphasized, certain water-soluble vitamins (B-complex and C) and vitamin K are involved in body defense mechanisms as well as in tissue repair and are required in increased amounts during the stress of febrile infections. Yet there is often a considerable reduction in the normal supply of these important nutritional elements in acutely ill patients who are candidates for antibiotic therapy.

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1. Pollack, H., and Halpern, S. L.: Therapeutic Nutrition, Prepared with Collaboration of the Committee on Therapeutic Nutrition, Food and Nutrition Board, National Research Council, Baltimore, Waverly Press, 1952.

the patient with infection . . .

not only fight the infection,

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More and more the realization is spreading that a patient needs a strong *personal* incentive to spur him into replacing blood. When Batavia, N.Y., doctors launched a blood "insurance" program a few years ago, for example, they discovered that 30 per cent of the people who were required to give blood as a condition of membership had never given blood before.

Dr. Trumbull says: "Until some responsibility is placed on the patient to replace the blood given him, either through the requirement of prior credit or a charge on the blood, blood will not be voluntarily donated by the members of families or friends. Therefore, I believe that any blood program, particularly in peace time, is not a sound one without such a provision."

Banks run on the replacement principle have had surprisingly little trouble maintaining adequate blood supplies. The Peninsula Memorial Blood Bank in California, for instance, has never had to buy a pint of blood from a professional donor in its thirteen-year history.

Patient Responsible

The Red Cross, of course, has long scorned measures aimed at making patients responsible for replacing blood. Within the past year, though, a number of Red Cross centers have had trouble meeting



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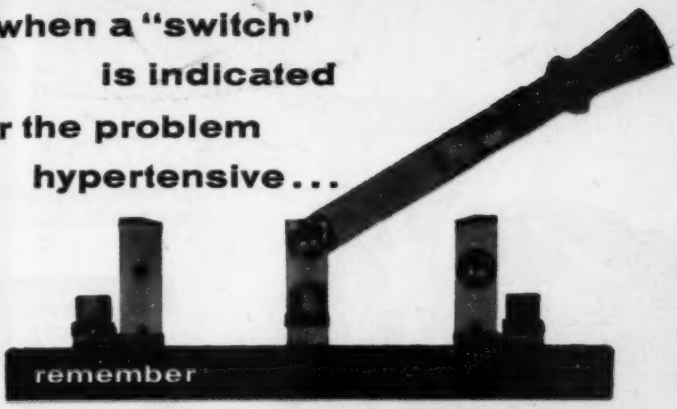
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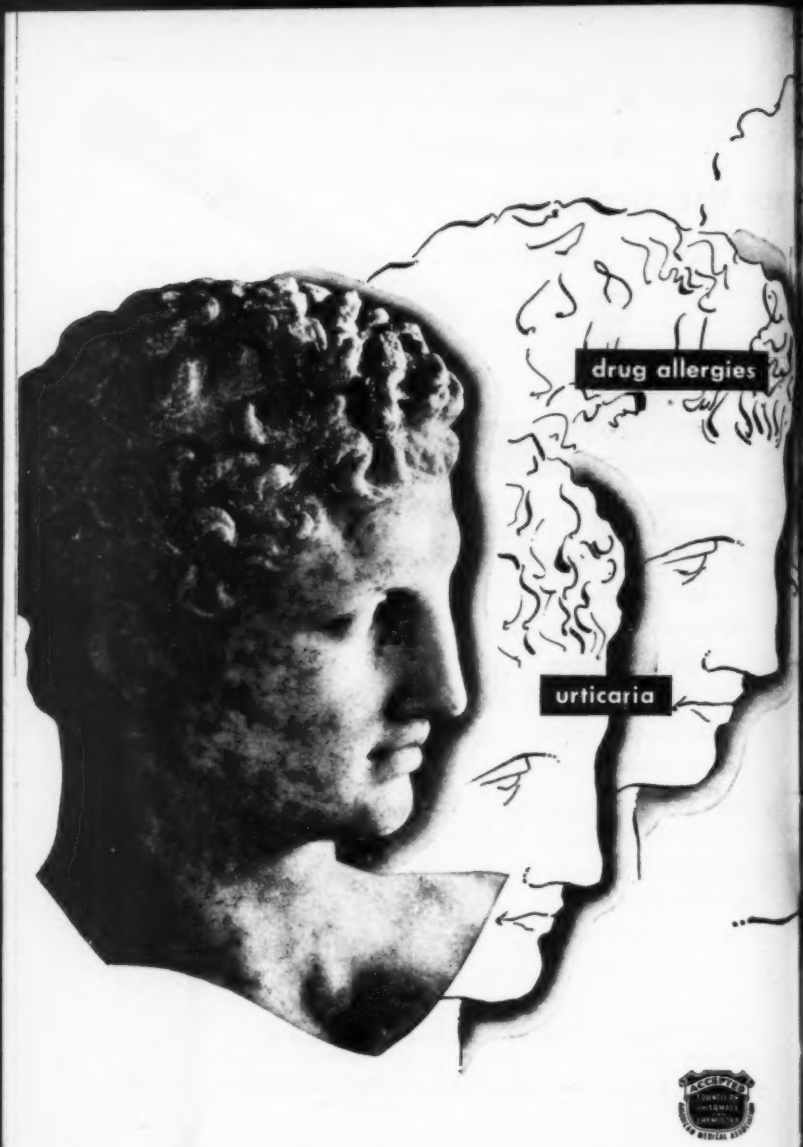
- the "vascular accident-prone" patient whose capillary fragility complicates treatment
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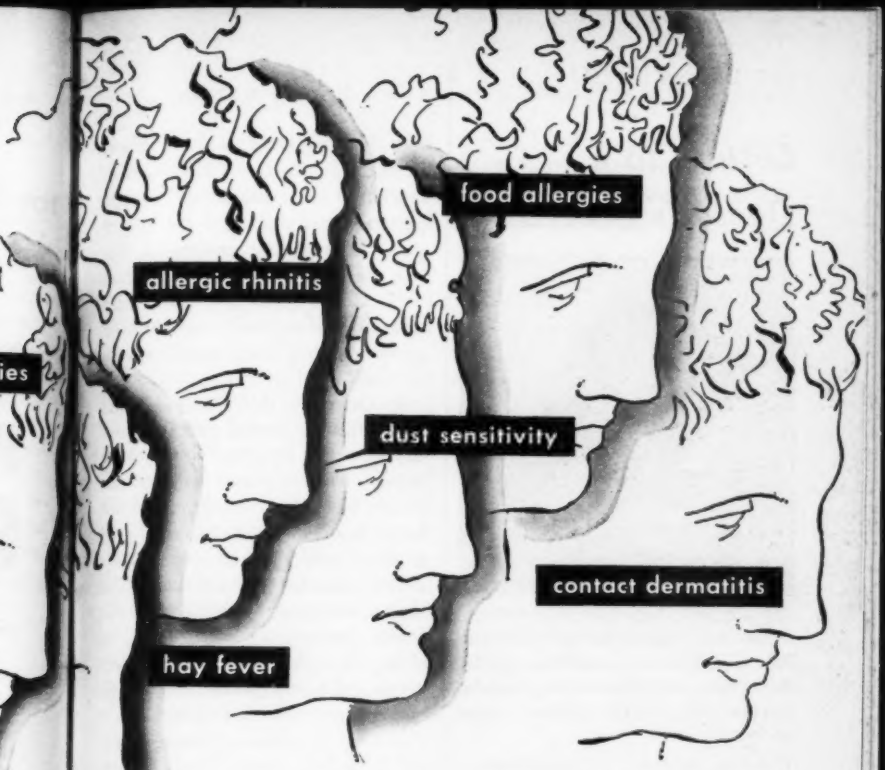
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their blood quotas. Last summer, for example, the Red Cross bank in Peoria, Ill., advised some Chicago hospitals that the usual amount of blood representing credits for Peoria patients was not available. Physicians in Nashville, Tenn., also reported having had considerable trouble getting blood supplies from the Red Cross.

In Detroit, a Red Cross regional center has for several years supplemented the supplies of hospital banks. But because this center couldn't supply all needs, a private bank opened recently—and sold 1,000 pints of blood its first month.

It will not be too surprising if the Red Cross soon modifies its traditional philosophy, which says, in effect, that blood shall be freely given and freely received. Already, one medical man points out, a few Red Cross centers are issuing "credits" to donors. Before long, he predicts, Red Cross banks will be charging replacement fees as well.

4. As contributions from national headquarters decrease, expect Red Cross regional centers to shunt onto hospitals more of the costs of blood collection and processing.

Current Red Cross policy, according to Dr. Grant, is that "There is no objection to a charge adequate to cover the actual cost of blood supplies and distribution only." So, since last fall, some twelve Red Cross centers have been billing hospitals at a rate of $1.75 to $2.50 a pint.

[MORE ▶

Few doctors quarrel with this change in Red Cross policy. In fact, some of them think it's one of the best things that has happened in a long time.

The 'Old' Attitude

"In the past," says a Pennsylvania M.D., "the Red Cross collected large sums of money from the civilian population, as well as about $6.50 from the Government for every pint delivered to the armed forces. The Red Cross has never admitted officially to the tax-paying public that it received Government money; but it has been quick to criticize other nonprofit banks which, being self-supporting, have had to make service charges to meet expenses. Perhaps now the Red Cross will admit that there is no such thing as 'free' blood."

5. Expect profit-making blood banks to start dying out.

Profit-making blood banks have probably served some useful purposes. Says one doctor: "I think it is fair to assume that the prime function of a blood bank is to get blood to the patient at the moment he needs it. Not once in my eight years' experience has the private bank in our county failed to provide, and promptly deliver, blood of the necessary type."

Another physician concedes that "Some of the persons who are now accused of unacceptable practices were pioneers in the field a few years ago." He adds, however, that "Times have changed, and it's obvious that some of these practices must be discontinued or modified."

Most of the authorities surveyed seem to feel that private blood

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banks will find it impossible to survive for long in any area where first-rate nonprofit facilities are set up. It's just a matter of simple economics, reasons one doctor: "Not only doesn't the community-sponsored bank have to make a profit, but it can count on getting a lot of volunteer labor and free publicity. The only way a proprietary bank can hope to compete with a good nonprofit program is to get its blood mainly from skid-row sources. I know that doctors in our area, at least, would never stand for that."

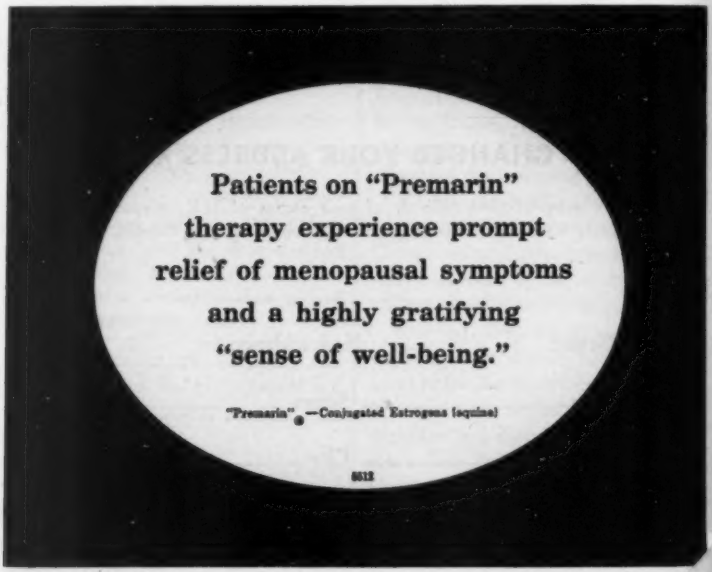
6. Expect to see more and more hospital banks consolidated into programs servicing an entire metropolitan area.

At last count, there were still more than 1,500 hospital banks in the country.

But the fact of the matter is that most of these are small—too small, generally, to process blood economically, stock adequate supplies of rare bloods, or warrant inspection by the National Institutes of Health.

A Single Bank

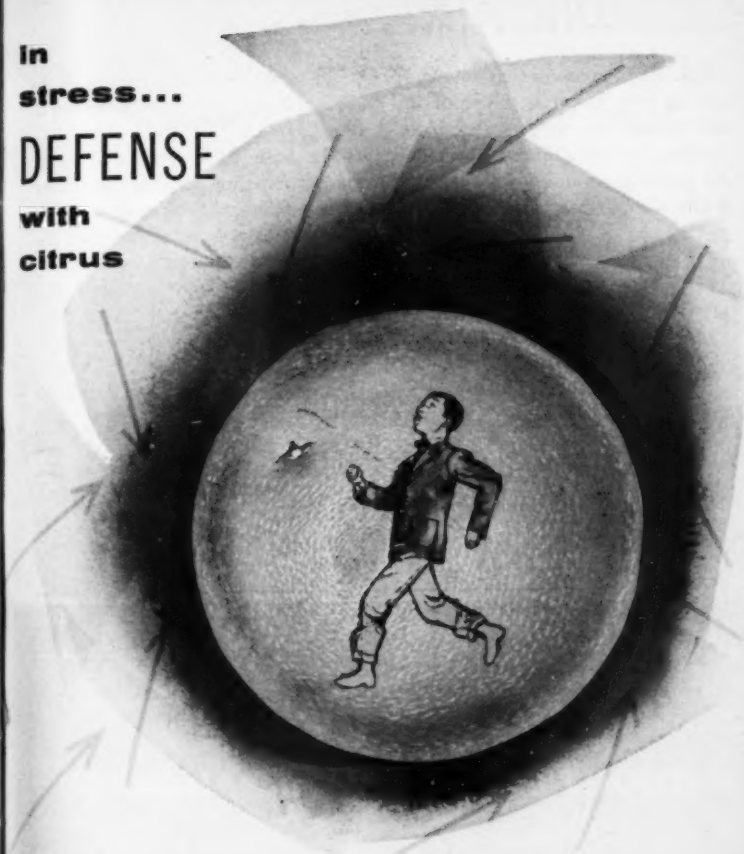
In any city where a half-dozen or so hospital banks are functioning independently of one another, it's reasonable to assume that a single bank, serving all the hospitals, could do the job better. This has already proved true in Milwaukee, Seattle, San Francisco, and scores of other



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cities. Even in towns that have only one or two hospitals, some of the advantages of large-scale blood banking can sometimes be obtained by pooling resources with hospital banks in near-by areas.

Close Ties Help

7. Expect blood facilities in rural areas to show marked improvement, thanks to increasingly close ties with big-city banks.

Already, quite a few banks—notably in California, Wisconsin, Minnesota, and New York—have worked out satisfactory systems for meeting blood needs in surrounding rural areas. An especially good system, many authorities feel, has been developed under the leadership of the Minneapolis War Memorial Blood Bank.

The basic idea there is to make the participating rural communities as self-sufficient as possible. If a town has even a small hospital, it's considered big enough to fill ordinary blood needs from among its own residents. Although the local hospital keeps only a few pints of whole blood on hand at any one time, it runs a donor club whose members agree to give blood on a rotating basis whenever the bank's supply gets low. (Club members are entitled to receive blood for themselves and their families without replacement fees.) [MORE ON 272]

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People being people, environmental factors contributory to gastric hyperacidity are hard to remove, even when their role is clearly defined. But, the physician has a sure, simple—even pleasant—way of relieving the acid distress caused by:

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XUM

Dependent-Care Issue Comes to a Boil

Something's due to pop as the Pentagon's latest plan stirs fires in Congress over what role the civilian doctor will play in military care

By John R. Lindsey

● "I've been on active duty with the Navy for fifteen months, and *I haven't treated a single serviceman for anything.* What it amounts to is that I had to give up my private practice to care for the dependents of a bunch of officers, who could well afford to pay their own way."

Complaints like this have been turning up more and more in this magazine's mail. They come from medical officers who say their time is taken up by the wives and children of the man behind the gun—and sometimes by his uncles and his cousins twice removed. Here's a sampling:

"What the hell am I doing in the Army anyway? All I do is deliver babies."

"I was a damn good surgeon once. Now I spend my time dispensing cough syrup!"

"Is it fair to draft doctors just to care for civilian dependents?"

"Did I have to give up my practice for this: to prescribe for colds for officers' wives and kids?"

This refrain has a familiar sound to the A.M.A. and to Defense Department experts who've been studying the problem of dependent care for quite some time. Last year

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they tried to get Congress to do something about it. This year they're trying again.

The Pentagon thinks it has a legislative solution to this seventy-year-old problem in its bill (H.R. 2685) now before Congress. Undiscouraged by previous failures, it thinks this bill—for a uniform program of dependent medical care—has a better than fair chance of going through.

Private physicians have hopes along the same lines. They like the idea of regularizing procedures for all three services. But they're frankly worried that Congress may not give the civilian practitioner his proper share in the new program.

The dependent-care problem has been growing haphazardly ever since 1884, when Congress wrote into law: "The medical officers of the Army and contract surgeons shall, *wherever practicable*, attend the families of officers and soldiers free of charge."

Inequities Crop Up

This single sentence has governed medical corps practice ever since. It appears verbatim even today in the United States Code.

Each of the three services has its own interpretation of "wherever practicable." And what's practicable in one is not always practicable in another. Inequities crop up everywhere.

The term "dependent" has never been clearly defined. In some areas, a second cousin gets free hospitalization only because "space is available." In other areas, a wife or child is turned away because the hospital is full, or the staff is too busy.

"It's well known," admits a Pentagon spokesman, "that some distant cousins have been getting free care at certain military establishments. High-ranking officers are often the worst offenders."

Some Pay; Some Don't

The Moulton Commission—the Citizens Advisory Commission headed by Dr. Harold G. Moulton, president emeritus of the Brookings Institution—reported that 82 per cent of military officers list dependents and that only 36 per cent of the enlisted men do. The total: 2½ million.

Members of a soldier's family living on a base get free care, even for minor ailments. Those living in areas without military clinics must pay their own way. Distance is often a determining factor.

The Moulton Commission found that at least 40 per cent of servicemen's dependents did not use military facilities at all. Their reasons varied, but at least half of them lived more than twenty-five miles from the nearest base.

A recent survey of maternity problems in the Los Angeles area drew responses like these:

¶ From a Marine sergeant's wife: "I didn't go to the base, because I didn't want to. You see one doctor;



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This is an actual sensitivity test with a strain of *Streptococcus pyogenes* on a blood agar plate. Note the high activity of ERYTHROCIN against this organism. This same streptococcus may be associated with *sinusitis . . . otitis media . . . tonsillitis . . . pneumonia . . . empyema . . . pharyngitis . . . septicemia . . . tracheobronchitis . . . streptococcal sore throat . . . scarlet fever . . . erysipelas . . . certain urinary tract infections . . . and certain cases of*

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then they rush you to another doctor for your delivery; and afterwards a different doctor takes care of you."

True to the Navy

¶ From a private's wife: "The Army clinic was too far away."

¶ From a petty officer's wife (who chose the Navy infirmary): "I'm in the Navy, and I'm entitled to that care."

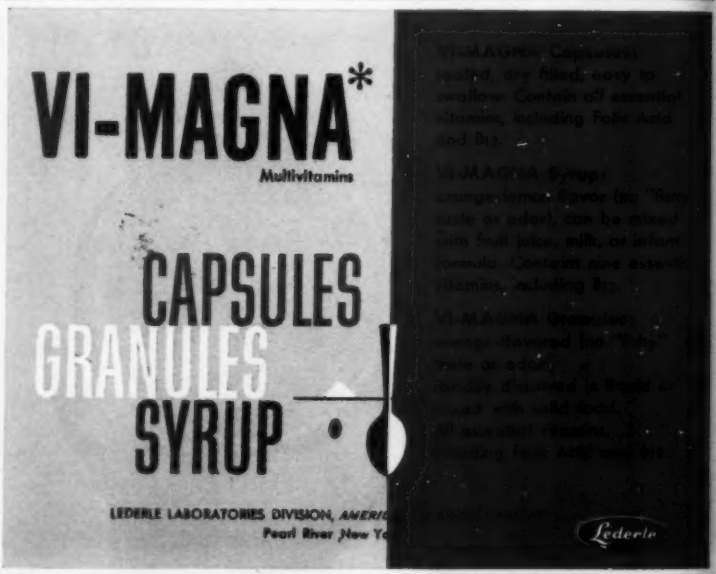
¶ From a seaman's wife: "I was sick at the beginning of my pregnancy and couldn't wait for a clinic appointment at the Navy infirmary."

The Defense Department's bill is aimed at eliminating these inequities. It defines eligible dependents as members of a serviceman's immediate family: his wife, his children under 21, his parents, and his parents-in-law (if they depend on him for more than half their support). The soldier's brothers and uncles would be barred; so would his sisters and his cousins and his aunts.

He Married a Wac

The husband of a Wac or a Wave could get in if he could prove she supported him.

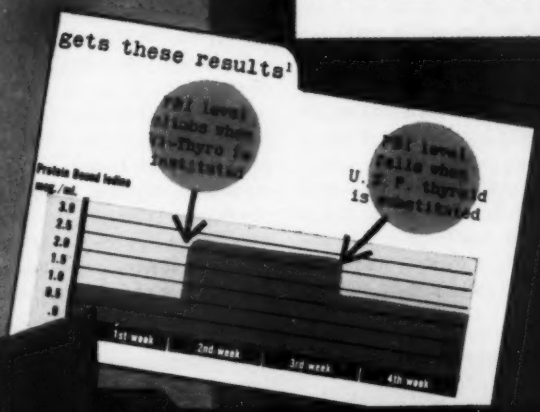
Medical care would be limited to "diagnosis, acute medical and surgical conditions, contagious diseases, immunization, and maternity



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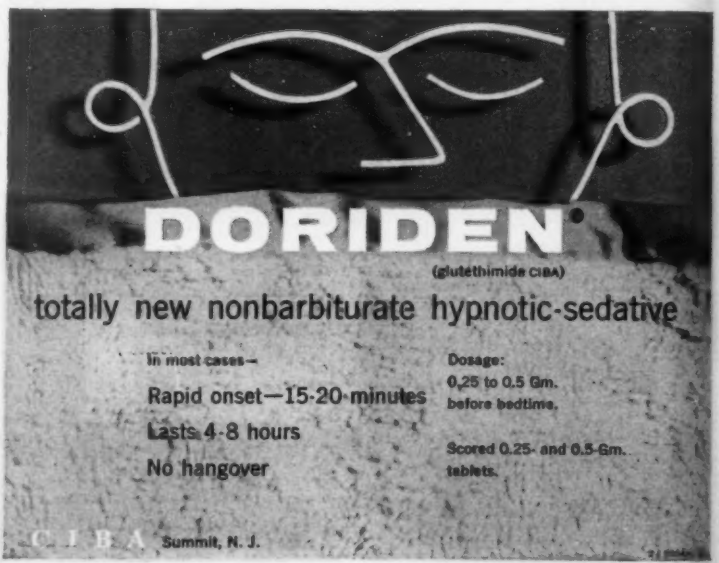
and infant care." Elective medical and surgical treatments would be out; so would hospitalization for nervous and mental disorders. Ambulance service or home calls would be excluded too, except in emergencies.

There's a special clause for widows and their dependent children: To get free care they would have to use military medical facilities. They would not be allowed civilian medical care of any kind at Government expense.

There's a place for civilian physicians in the bill, but it's not as big as most of them would like. Dependents other than widows and their children could get civilian medical care at Government expense under certain circumstances. The Secretary of Defense could issue regulations defining these circumstances, but the bill spells out three of them:

1. If military facilities were not available, or
2. If they were not able to supply the type of treatment needed, or
3. If the case were a bona fide emergency.

In these circumstances, a soldier's wife could go to her family doctor or to a civilian hospital at the Government's expense. The private physician (and/or the hospital) would then bill the Government direct. The dependent would pay the first $10 out of her own pocket (ex-



cept in maternity cases), plus 10 per cent of the total bill.

The Government would pay the rest; but the Secretary of Defense—after consulting the local medical association—would have the last word in setting fees and costs.

One more thing. The door is left open to proposals like the one recently advanced for Government-financed Blue Cross and Blue Shield coverage for service families. The Defense Department bill would permit the Secretary of Defense to authorize some form of private insurance.

That's the substance of the legislative solution proposed by the Pentagon. Whether it will get through Congress in that form is an open question. The medical profession hopes changes can be made to put more emphasis on civilian care. The Pentagon likes it the way it is.

A.M.A. Position

The proposed legislation follows the recommendations of the Moulton Commission. The A.M.A. has never been happy about those recommendations.

So far, the Association has taken no formal action on the new Defense Department bill. But its position is plain. Former A.M.A. President E. J. McCormick puts it this way:

"It's always been the A.M.A.'s



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belief that civilian facilities should be utilized first, and that the use of military facilities should be restricted to emergency situations and remote areas. This philosophy will be completely reversed if the recommendations of the Moulton Commission are accepted."

The Moulton report, Dr. McCormick believes, "approaches the problem entirely from the viewpoint of the armed forces, with little or no regard for the recommendations of interested civilian organizations."

This view is shared by Dr. Frank E. Wilson, chief of the A.M.A. Washington office. He says:

"It's not true that we're against dependent care. We're *for* it. Our differences with the Defense Department concern *where* and *from whom* the dependents get medical care.

"We agree with the Defense Department that dependents eligible for dependent care should be clearly defined by Congress. We agree that dependents of all three military services should be treated alike.

In Reverse Order

"We agree that in remote areas of this country and at bases overseas, dependents should get military care.

"But we can't agree with the Moulton philosophy that only if military facilities aren't available, should dependents receive civilian

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References

(1) Kirby, W. M. M.; Waddington, W. S., & Doornink, G. M.: Antibiotics Annual, 1953-1954, New York, Medical Encyclopedia, Inc., 1953, p. 285. (2) Finland, M., & Haight, T. H.: *Arch. Int. Med.* 91: 143, 1953.

PARKE, DAVIS & COMPANY DETROIT 32, MICHIGAN

care. Our viewpoint is just the opposite: We feel that dependents should first rely on civilian care. Only if this isn't adequate, should they turn to military facilities."

'Morally Wrong'

Addressing the members of the San Diego County Medical Society recently, Dr. Milo A. Youel called the Defense Department bill a "go-ahead signal for further expansion of military facilities for dependents." This, he said, "means more doctors in the service to take care of them . . . Drafting doctors to care for civilian dependents, particularly when they can be cared for better on a private basis, is morally wrong and basically un-American."

Some physicians think there's much to be said *for* dependent care in military facilities. Reason: It gives a military doctor a more varied practice than that afforded by healthy young men.

Career Incentive

In a letter to MEDICAL ECONOMICS, Dr. Amos R. Koontz of Baltimore writes:

"Were it not for dependent care, medical officers in all specialties would have their practice limited to adult male patients. Even to a general surgeon this would be undesirable. It would leave no scope for gynecologists, say, or pediatricians."

Both the Moulton Commission and the Health Resources Advisory Commission, headed by Dr. Howard A. Rusk, make this point: Dependent care offers an incentive to physicians considering a military career. The Moulton report calls it "an important factor in getting and retaining competent career medical officers." And that, suggests Rusk, may be the soundest way of ending the doctor draft.

While the controversy waxes, a Republican President, sympathetic to the morale problems of both the military and the medical profession, may look to a Democratic Congress for help. Compromise is always possible.

Civilian M.D.s

Dr. Frank Berry, Pentagon medical chief, has hinted that more reliance may have to be placed on civilian doctors to make an expanded program of dependent care work effectively. But no less reliance on existing military facilities can be expected. He points out that "about 60 per cent of all out-patient care given in military facilities is in obstetrics, gynecology, and pediatrics."

Dr. Berry adds: "I'm favorably inclined toward greater use of civilian doctors in military out-patient departments. The Veterans Administration is authorized to employ young doctors at $25 per session. I'd like to see the military services get the same authority. Then military M.D.s wouldn't have to handle the dependent care load alone."

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My Patient Just Died

By Ambrose B. Karter, M.D.
As told to Richard L. Frey

AS YOU READ THIS ARTICLE, many of your patients may be reading it, too. For it's appearing, word for word as you see it here, in the current issue of Cosmopolitan.*

Using the pseudonym Ambrose B. Karter, a physician describes a tragic case that convinced him of the need for systematic follow-up of patients. Since the ethics and advisability of such reminders are now being debated by many M.D.s across the country, we think you'll be interested in Dr. Karter's views—whether or not you agree with them.

For other doctors' thoughts on this subject, see "Is It a Good Idea to Send Reminder Notices?", MEDICAL ECONOMICS, January, 1953.

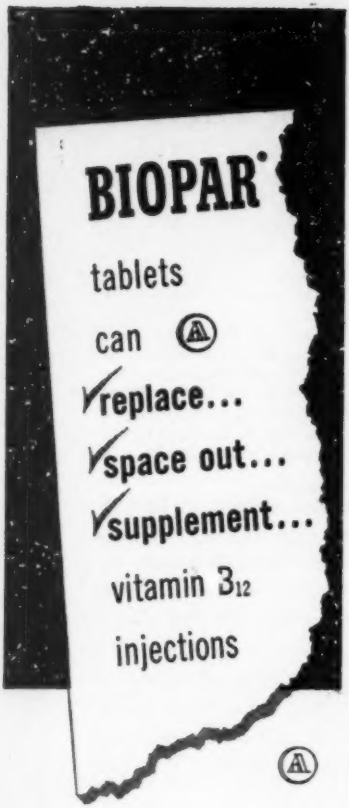
● I am about to sign the death certificate of Donald Hammer. My name will appear at the bottom as the doctor attending him. But, ever since they called me to try to save him, I have been asking myself whether my name should not be written on another line—the line that is captioned, "Cause of death."

Something that went wrong while I was taking care of him? No, that was just the trouble. Nobody was taking care of him—least of all Don himself. But somebody should have, and my conscience is charging: "Who else but you?"

You might say that Donald Hammer wasn't my patient—wasn't really any doctor's patient. Oh, I had a card for him in my file. But in the seven years I had taken care of his family, his card had just two entries on it. Some shots when he went abroad, and an X-ray and strap-up of his ankle when he limped in one day after falling off a step-ladder. Then, last May, he came into my office spouting symptoms. [MORE ▶

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MY PATIENT JUST DIED

"I need something to pep me up, Doctor," he said. "Been feeling a little heavy and tired lately. And I get a kind of stuffed feeling of indi-

A FOLLOW-UP on patients who have known diseases of a possible progressive nature is a part of good medical care and it is a practice that has long been followed in the profession. This obligation of the physician is clearly stated in our Principles of Medical Ethics.

Although ideally each person should have a family doctor to whom he can look for advice and guidance, actually he often goes to a number of physicians for different types of medical service. Thus few doctors can, at any one time, be sure that their patients are not also patients of other physicians, and they are therefore hesitant to make a vigorous follow-up.

Walter B. Martin, M.D., President
American Medical Association

gestion once in a while after meals. Need to take off a few pounds, I guess. But right now I've got a business trip coming up and I have to be on the ball. Got any new wonder drug that combines bicarb with a supply of new energy?"

"Who has been taking care of

you, Mr. Hammer?" I asked him.

He looked blank. Then he said, "You mean who's my doctor? Why, you are, I guess."

He Needed Help

It was news to me, but he sure needed a doctor. His weight was way over two hundred and his blood pressure made my gauge shoot up like a geyser. Just hoisting himself onto my examining table made him puff and pant, and I was pretty sure that his "indigestion" wasn't coming from what he ate. True, my stethoscope heard no sounds of heart trouble, but I told him I wanted to take an electrocardiogram. [MORE ▶

TO PROTECT the public from unethical practitioners, the Principles of Medical Ethics of the American Medical Association strictly forbids advertising or solicitation of patients in any way. In a local situation involving the sending of routine follow-up notices by a physician, it is the responsibility of the local medical society to decide whether such notices can be construed as advertising or solicitation.

Homer Pearson, M.D., Chairman
Judicial Council
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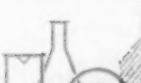
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"When I come back, Doc," he promised. "Just fix me up for my trip."

That wasn't ideal, but he'd been getting along without medical advice for years. There was no urgent reason for me to insist that he postpone his trip. I read him the riot act about his weight and blood pressure, put him on a strict diet, and gave him some medication to make him feel better. I told Hammer, "I am prescribing only enough to take care of you while you are away. Remember, I want you to come in and see me as soon as you get back."

He didn't, of course. Last night, when I examined him, he looked as if he had tried to follow some of my advice. I'd guess he had managed to take off twenty pounds. Maybe he'd brought his blood pressure down a few points, too. By the time I saw him, it was too late to measure.

Hilda Hammer will find it hard to take. Her husband had never hinted at trouble, never mentioned his visit to me. "Why didn't you warn me?" she will ask bitterly.

And, unfortunately, I will be able to answer only, "I told him to come back."

He Was an Ostrich

Was that enough? What right have I to say that I expected him to be sensible, to behave like an adult, to come and be checked as I asked him to? Donald Hammer was no different from a lot of other people I've treated. He was just the opposite of a hypochondriac—an ostrich. He just wanted something to get him past this trip, this month,



OUR CONCERN is to save more lives by detecting cancer in its early, eradicable stages. The effective way to do this is by periodic check-up. That makes the family doctor the spearhead in the battle; the success of his efforts to bring patients back to be checked can mean the difference between life and death.

Nathaniel Robin, M.D., Chairman
Professional Advisory Committee
Cancer Committee
Nassau County (N.Y.)

this year. If anything was really wrong, he wasn't anxious to know it.

Since he was feeling better, why see the doctor?

Technically—and it so appears on the death certificate—Donald Hammer died of natural causes. Actually, I believe he died of neglect. His own, of course; but how much was mine?

Legally, none at all. The law requires far less of a doctor than most of us require of ourselves. We aren't, as some suppose, compelled to treat anybody and everybody who needs or thinks he needs a physician. We can (but seldom do) drive past the scene of an accident, or refuse to leave the office on a call, even if it's an emergency and no other doctor is available. We can refuse to treat a patient who comes or is brought to us.

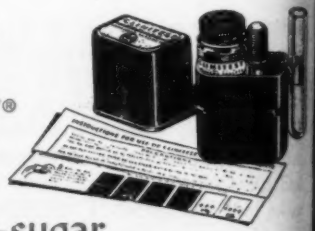
The Doctor Is the Judge

But once we accept a case, we're bound to see that the patient can get the medical service he needs—and that goes whether he pays for it or not! A doctor can be sued—and soaked—because he didn't come back to see a bedridden patient, even though the patient did not ask him to return. The courts have held that in any case of serious illness, the doctor, not the patient, has to judge whether or not his ser-

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*Barach, J. H.; Duncan, G. G.; Joslin, E. P., and Root, H. F.: Diabetes Mellitus, in Conn, H. F.: Current Therapy 1954, W. B. Saunders Company, Philadelphia, 1954, p. 368.

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1. Wagner, E., and Hunsicker, A., N.Y. Wagner Ed., J., Dec. 1951, 1952.
2. Clare, C. E., and Perkins, F. W., Endocr. Mod., 23:203, 1954.

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vices are still required. He cannot force treatment upon a sane adult, however. Having warned Donald Hammer, I had discharged my legal duty.

Doctors' Dilemma

Yet I think that most doctors feel as I do—that our moral responsibility goes further than that.

We've allowed ourselves to be held back by concern that some patients, or perhaps some of our fellow-doctors, may think we're chasing fees. [MORE]

MOST SURGEONS, including the surgical specialists, see patients who are referred to them for surgical treatment by general practitioners, internists, or other physicians who do no surgery. The surgeon, therefore, is not as a rule concerned with routine health maintenance examinations.

He is, however, vitally concerned with follow-up examinations at regular intervals after operation. In cancer and in certain other diseases the future well-being of the patient may depend upon his post-operative supervision.

I. S. Ravdin M.D., Chairman
Board of Regents
American College of Surgeons

There is no single solution to this problem. That was proved recently, when the doctors' magazine MEDICAL ECONOMICS asked twelve hundred doctors, including both general practitioners and specialists, "Do you think it is a good idea to send reminder notices? Do you think it is ethical?"

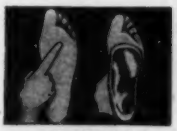
Two out of three answered "Yes" to the first question. Yet only one doctor in three [of those who said

THE MODERN VIEW of ethical follow-up, as expressed by the recent statement of the Committee on Questions of Ethics of the Medical Society of the State of New York, makes it clear that a physician today is free to act in good conscience to save lives without fear of losing face. No code of medical ethics was ever meant to curtail a doctor's efforts to fulfill his responsibility to his patient.

Fair-minded medical graduates can readily distinguish between legitimate follow-up and "advertising"; sensible patients should appreciate the difference between professional interest and fee-chasing.

Dan Mellen, M.D., President
Medical Society of
the State of New York

Weak Metatarsal Arch... Morton's Toe



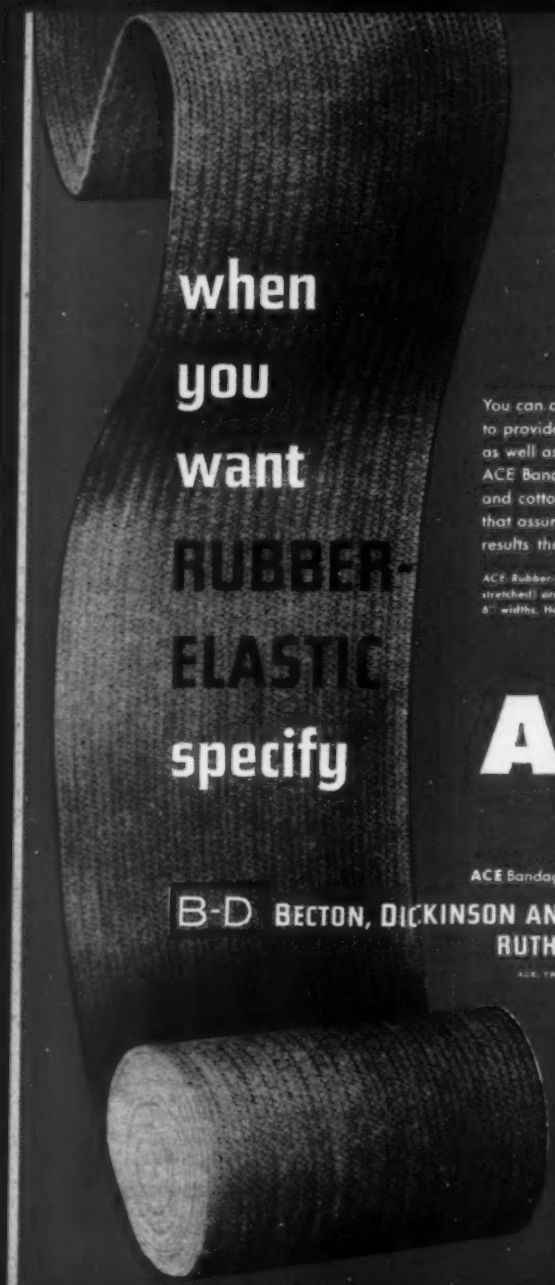
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"Yes"] actually sent reminders to "some patients" and only one in ten routinely sent reminders to all.

When I raised this question with the Medical Society of the State of New York, the Committee on Questions of Ethics answered, in part: "A physician may ethically, and should, make a reasonable effort to follow up a patient for the purpose of administering needed treatment . . . "

I myself now believe that mere routine reminders to the patient are not enough. If the routine reminder gets no reply, that fact should be brought to the doctor's personal attention so that he can decide whether the case demands a more urgent follow-up. From now on, that's my system.

If any of my colleagues think that's unethical, or if some of my patients think it's fee-chasing, I can stand that better than I can stand the way I feel today about signing Donald Hammer's death certificate.

END



"Jim wanted a boy. I just wanted breakfast in bed."

Good News About Blood Banks?

[CONTINUED FROM 244]

The rural banks can call on Minneapolis for rare types of blood, as well as for special laboratory work, consultation in difficult cases, and advice on administrative and technical problems. They also can send their outdated blood to the main bank, where it is processed and sent back as plasma.

8. Expect lay groups to play a bigger role in blood-bank affairs from now on.

Actually, medical men have never had a monopoly on interest in blood banking. The leading voice behind the Milwaukee program, for instance, has not been a doctor, but a doctor's wife. One physician recalls that the first demands for a nonprofit bank in his county came from business and labor leaders, early in World War II; and at first, he adds, many of his colleagues flatly refused to take any interest or responsibility in the project.

A Joint Effort

The modern blood bank is necessarily a complicated structure, requiring the services of specialists in fields as diverse as public relations, accounting, refrigeration, and med-

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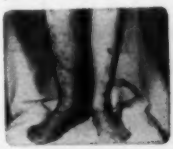
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icine. So broad participation by lay groups is more to be welcomed than feared. Dr. T. J. Greenwalt, medical director of the Milwaukee Blood Center, puts it this way:

"Blood banking is clearly a cooperative effort. The physician is responsible for the scientific aspects and the layman is responsible for the development, recruiting, and organization."

9. *Expect to hear less talk about "bureaucratic" control of blood facilities.*

Despite the hoped-for development of the National Blood Foundation, there's a strong trend toward decentralization and local autonomy. This trend seems to be especially noticeable in the Red Cross program.

Since the foundation will be run by five interested organizations, there is no longer a real threat of domination by any one. And as for the possibility that the Government will take over the blood program—well, every doctor surveyed says that, barring a national emergency, he can't see much chance of that happening.

Says one: "If we do the job we're capable of doing, the Government will have no reason to interfere. If we don't do it—with all we know about blood today—then we'll *deserve* to have the Government step in and run things." END

BASIC IN HYPERTENSION

'Sandril'

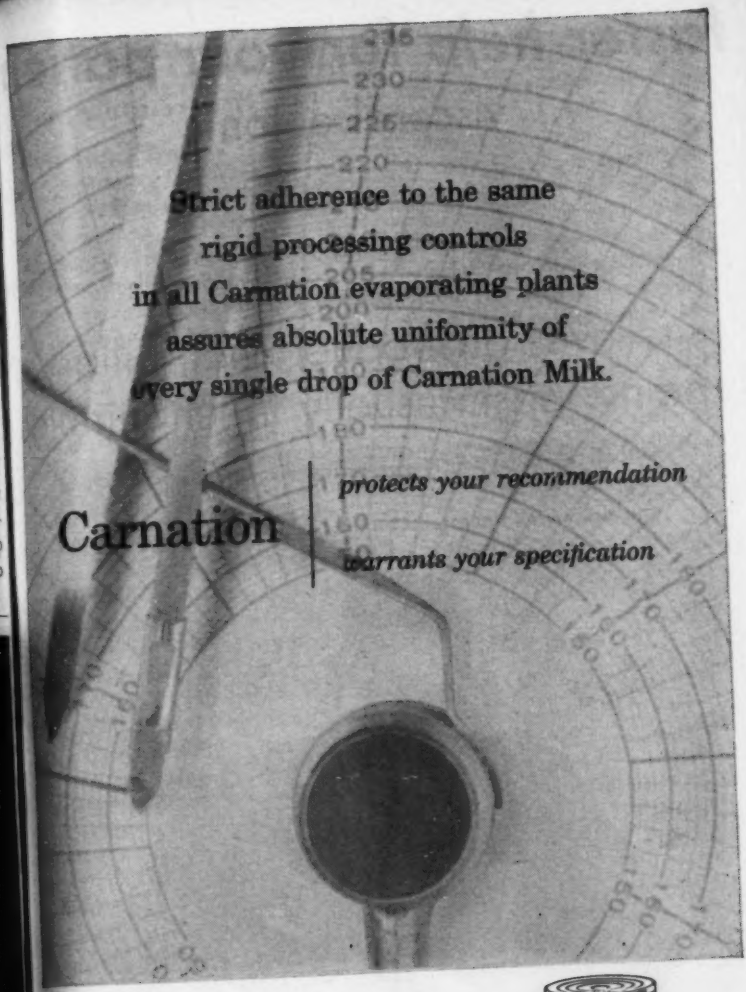
(RESERPINE, LILLY)

In hypertension, 'Sandril' often produces the desired reduction of blood pressure. In severe cases, 'Sandril' supplements the action of 'Provell Maleate' (Protoveratrine A and B Maleates, Lilly).

SUPPLIED:
Tablets—0.1, 0.25, and 1 mg.
Elixir—0.25 mg. per 5-cc. teaspoonful.

Lilly





Doctor, may we have your support for



faster help for your patien

visceral eutonic

DACTIL

PLAIN AND WITH PHENOBARBITAL

relieves gastroduodenal, biliary pain⇄spasm usually in ten minutes

eutonic: abolishes **pain⇄spasm** without interfering with normal tonus or motility

unusually well tolerated: free from "antispasmodic" side effects and does not affect gastric and biliary secretion



Laboratories PIONEERS IN PIPERIDOLS

The Kintner Pension Plan

[CONTINUED FROM 134]

could legally require them to defend a Kintner-type set-up in court.

But *would* it do so? Opinions differ on this point. Says one tax consultant:

Contrary Opinions

"The Government will almost certainly contest any similar plan set up outside the jurisdiction of the Ninth Circuit Court of Appeals. The Kintner ruling is just a freak decision. Partners have a proprietary interest in the firm; and under no circumstances can they rightly be considered in the same class as other employes."

Other tax experts believe this to be a short-sighted view. The U.S., they say, is unlikely to oppose any further tax-exempt pension plans modeled on Kintner's because:

1. The favorable ruling in the Kintner case gives other physicians a big talking point in court, where precedent has always been a telling argument.

2. Such plans would never become so numerous that they'd result in a serious loss of revenue to the Government. The reason: There are some real disadvantages to the association-plus-pension package that will probably keep many doctors from wanting it.

These disadvantages are worth citing:

¶ Though the money deposited in the physician's name is definitely his, he can't get it—under any circumstance short of withdrawing from the group—until he hits the specified retirement age. So he can't count on it for use in an emergency.

¶ Instead of paying money into the pension trust, the doctor might do better in the long haul by investing it wisely on his own.

¶ To qualify for a tax-exempt retirement plan, the medical man must be willing to give up a fair amount of the independence that he enjoys as a solo practitioner or as a partner. He must *really* become an employe, must *really* accept a salary in lieu of fees.

How to Do It

In spite of these stumbling blocks your medical group *may* want to make the change-over. If so, you'll need a good lawyer who's familiar with tax and pension laws. His first task will be to re-form your partnership into an association. And this association *must resemble a corporation as closely as the Montana clinic does.*

According to the courts, there are four important areas in which the Kintner association is like a corporation: (1) its management; (2) its financial structure; (3) its operation; and (4) its duration. Let's take a closer look at each of these four points:

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Phosphorated Carbohydrate Solution



A unique formula for *oral* administration . . . containing no drugs likely to induce untoward effects . . . and stabilized at an optimally adjusted pH, EMETROL has proved dramatically effective in epidemic and other types of functional vomiting.[1-3] In an 18-month study, Bradley and associates obtained excellent responses in 172 children, often with a single dose of 1 to 3 teaspoonfuls. EMETROL is easy and pleasant to take, safe for all age groups.

IMPORTANT: EMETROL must always be taken *undiluted*. No fluids should be allowed for at least 15 minutes after each dose.

DOSAGE: For infants and children, 1 or 2 teaspoonfuls every 15 minutes until vomiting stops. For adults, 1 or 2 tablespoonfuls.

SUPPLIED: In bottles of 3 fl.oz. and 16 fl.oz., through all pharmacies.

In nausea of pregnancy, EMETROL has produced favorable response in 3 out of every 4 cases, usually within 24-48 hours.[2] Recommended as "free of annoying side effects . . . a safe and physiologic agent . . ."

1. Bradley, J. E., et al.: J. Pediat. 38:41, 1951. 2. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. 65:311, 1953. 3. Tebrock, H. E., and Fisher, M. M.: M. Times 82:271, 1954.

Literature and sample on request

KINNEY & COMPANY, INC.
COLUMBUS, INDIANA

Management. Unlike a partnership (where each M.D. usually has an equal voice in management), the Kintner association is run by a five-man executive committee elected from the ranks of the doctor-members. This committee has the duties of a corporate board of directors: It elects officers, fixes doctors' salaries, makes policy decisions, and keeps official minutes of its meetings.

Financial structure. Since the association owns all the assets, a doctor joining the group doesn't put up capital to buy a share (as in a partnership). He merely goes on salary. And when he retires, he gets only the pension-plan benefits. (If, at

Here's How Retirement Savings Pyramid Under a Tax-Favored Pension Plan

If at this age:	You had accumulated this much without a pension plan:	Then, under a tax-exempt pension plan, you could have accumulated this much:
35	$ 700	$ 1,000
45	8,500	13,200
55	21,300	36,800
65	40,600	79,100

YOU COULD DOUBLE YOUR MONEY under a tax-favored pension plan—like this: Assume that a married doctor (with average lifetime net earnings of $14,000 a year) is able to earmark for retirement $1,000 a year *before* taxes (or about $700 *after* taxes) starting at age 35. Under ordinary conditions, his annual $700 (invested at an optimistic 6 per cent) will grow to $40,600 by the time he reaches 65. But if he put the money into a tax-favored pension fund (earning the same interest), he'd end up with *twice* that much. Why? Because he'd pay no tax on earnings put into the fund; so each year he'd save the full $1,000. Furthermore, he'd pay no tax on the interest earned by the pension fund; so all interest could be immediately reinvested.

some future time, the doctors voted to dissolve the association, its assets would, of course, be divided in equal portions among the then-current members.)

Operation. Like a corporation, the association employs the doctors. It collects all fees for their professional services; it furnishes them with equipment; it pays all maintenance expenses. Furthermore, it pays the employer's share of Social Security and unemployment taxes; and it witholds Social Security and income taxes from the doctors' salaries.

Duration. Death or withdrawal of a member doesn't affect the life of the association; it can be dissolved only by the vote of a specified percentage of the members. Since new members are admitted as older ones retire, the association is self-perpetuating.

Who Gets Pensions?

Not only the articles of association, but also the provisions of any tax-exempt pension plan, must be drawn up carefully, in order to meet Internal Revenue Code requirements. For instance, there can be nothing exclusive about any such retirement program; it must apply to non-doctor employes as well as to the physicians themselves.

For this reason, it's well to set up certain limitations (subject, of



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Dosage: For mood elevation, initially 1 to 2 tablets before both breakfast and lunch.

Rauwidrine®

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FOR OBESITY Rauwidrine curtails appetite without the "black mood" feeling of deprivation.



course, to Internal Revenue Service approval). Otherwise, the association will be paying money into the fund for all sorts of nonpermanent personnel, with resultant lowered net profits and endless bookkeeping troubles.

Limited Enrollment

To preclude any such situation, the Western Montana clinic limits enrollment in its plan to employes who are over 30 and who have worked for the association for at least three years. At the time of the change-over, in 1948, the doctors and other staff people were permitted to meet this requirement by counting their years with the old partnership.

The courts acquiesced in this arrangement. But, again, would courts elsewhere do so? Possibly not. Some lawyers consider that in this respect, too, the Kintner group was lucky.

Get Legal Advice

So there's no guarantee that, in a similar situation, such a liberal interpretation of tax laws and pension regulation would apply to *your* group. This, of course, merely points up once more the fact that you'll need to obtain sound legal advice before you and your partners decide to put all your retirement dollars in one basket.

True, Arthur Kintner has blazed a trail. But the territory he opened up has yet to be fully explored. END

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no toxic by-products...

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effervescing analgesic-antipyretic...speeds relief
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